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HEALTH CARE FOR THE UNINSURED: THE ROLE OF SAFETY NET PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

EXAMINING THE ACCESS OF ESSENTIAL HEALTH CARE SERVICES FOR THE UNINSURED AND MEDICALLY UNDERSERVED INDIVIDUALS, FOCUSING ON CERTAIN SAFETY NET PROGRAMS TO REDUCE THE BARRIERS AND INCREASE HEALTH INSURANCE ACCESS TO THE UNINSURED, AND THE PROPOSED COMMUNITY ACCESS TO HEALTH CARE ACT

MARCH 23, 2000

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HEALTH CARE FOR THE UNINSURED: THE ROLE OF SAFETY NET PROVIDERS

THURSDAY, MARCH 23, 2000

U.S. SENATE,
SUBCOMMITTEE ON PUBLIC HEALTH,
OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room SD–430, Dirksen Senate Office Building, Senator Frist (chairman of the subcommittee) presiding.

Present: Senators Frist, Jeffords, Kennedy, Dodd, and Reed.

OPENING STATEMENT OF SENATOR FRIST

Senator FRIST. Good morning. I apologize for running a few minutes late for a very important hearing this morning, one that I am very excited about because it really does capture for me a lot of the dynamics of an area which has, I believe, in the past been less than adequately addressed in a hearing format. I believe that today, with our two superb panels of witnesses, at the end of the next couple of hours, we will all be better-educated—I know that I and my colleagues will be.

Today's hearing is entitled, "Health Care for the Uninsured: The Role of Safety Net Providers." We are here today to discuss the Nation's safety net system which is a critical factor in ensuring access to quality health care for America's uninsured.

As many of you know, a few months ago, I joined hands with a bipartisan and bicameral group of members and put forth a multifaceted approach to address the varying needs of the uninsured. Today's hearing will focus on an important aspect or piece of that comprehensive approach—our safety net providers and will focus on the critical role that they play in serving the uninsured and medically underserved populations.

Despite America's unprecedented economic growth, we have an uninsured population that is increasing at about 3,000 people a day, about one million people each year. It has now increased to 44 million people, which is an increase that I believe we must address in a systematic and comprehensive way. We must support the life-saving role that our safety net providers play in serving our most vulnerable populations, those populations who cannot afford to pay out-of-pocket for their health care.

This morning as we examine our safety net system, we will focus on three primary programs—the National Health Service Corps,

the Consolidated Health Centers Program, and the Community Access Program. Together, these three programs service millions of medically underserved areas, serving the uninsured and others.

Since 1972, the National Health Service Corps has placed over 20,000 health care providers in health professional shortage areas through scholarship and loan repayment programs. Today, over 4 million receive care from 2,500 NHCS providers in the field.

However, even with over 4,000 shortage areas being served by the National Health Service Corps, only 12 percent of the need has thus far been met.

As the committee looks to reauthorize the program this year, these are among the issues to be considered, and unmet need will be an important one of these issues.

In 1996, the Health Centers Consolidation Act reauthorized the community health centers, the migrant health centers, health centers for the homeless, health centers for residents of public housing, and the Healthy Schools Program, until 2001. Today, these health centers serve nearly 9 million people, 41 percent of whom are uninsured with one-third of those uninsured being children.

Health centers today must operate in an environment that is very, very different from even a few years ago. The result of a health care industry which continues to evolve at a very rapid pace. Each year, health centers are faced with a growing number of uninsured. Demographic changes and increased reliance on managed care and decreasing Medicaid payments have placed new financial pressures on health centers' ability to continue to provide care.

As we look to reauthorize this program, it will be critical to acknowledge and address all of these factors to ensure that our Nation's health centers can continue to meet the enormous need for health care services.

Providing support for the development of integrated systems is one aspect of improving our safety net system. The Community Access Program, although not authorized, received appropriations of $25 million for fiscal year 2000 in an effort to assist communities and safety net providers to develop that important infrastructure necessary to participate in integrated health systems and coordinate care for the uninsured.

As we continue to address the needs of our safety net system, integration and collaboration within communities to provide care will all be important components in strengthening the system overall.

I am very pleased to have so many distinguished witnesses today and especially want to welcome my Tennesseans who are with us, as well as the many representatives of community health centers who are in the audience today.

In terms of procedure for our witnesses, we will follow the traditional committee policy with regard to opening statements, allowing individuals and my colleagues to place statements into the record. We will hear brief opening remarks from our witnesses on each of the two panels. I would like panelists if possible to keep their remarks relatively short, approximately 5 minutes in length. We will be using our lighting system, although we will not be using it too strictly, because I want you to be able to make all the important points that you would like to make.

After each panel completes their opening remarks, we will have a period for questioning. Then, we will keep the hearing record open for individuals who would like to submit no more than 10 doublespaced pages of written testimony until March 30, 2000, at which time the hearing record will be closed.

We have two panels today. The first panel will examine the National Health Service Corps, the Consolidated Health Centers Act of 1996, and the Community Access Programs and the important role they play as safety net providers.

Dr. Claude Earl Fox is administrator of the Health Resources and Services Administration which leads the Nation's efforts to increase access to health care for all Americans through a broad array of grant and health promotion programs. In this role and in his previous role as HRSA's acting administrator, Dr. Fox has been instrumental in many departmental initiatives, such as SCHIP, the State Children's Health Insurance Program, the Presidential Initiative to Eliminate Racial Disparities in Health, and Healthy People 2010. He has also enjoyed a distinguished public health career at the State and local levels. He received his M.D. degree from the University of Mississippi School of Medicine and a master of public health degree from the University of North Carolina.

Dr. Janet Heinrich is associate director of the Health Financing and Public Health Issues Division at the U.S. General Accounting Office. As a witness representing the GAO, Dr. Heinrich will focus on the GAO report on community health centers, released today. She was director of the American Academy of Nursing for 7 years and previously served as director of extramural programs within the National Institute of Nursing Research at the NIH. She is a graduate of the University of Michigan School of Nursing and in addition received a master's of public health from the Johns Hopkins University and a doctorate of public health from Yale.

I want to formally welcome both of our panelists at this juncture.

Senator Reed, would you like to make an opening statement? If not, we will proceed with the witnesses.

Senator REED. No, Mr. Chairman. Thank you.

Senator FRIST. Thank you.

Dr. Fox, if you would begin, and again, I appreciate your being with us today.

STATEMENTS OF CLAUDE EARL FOX, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD; AND JANET HEINRICH, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. Fox. Thank you, Senator. I am pleased to be here. You have my written statement.

I am accompanied by Dr. Marilyn Gaston, who is associated administrator for the Bureau of Primary Care, and many other staff and people who have woven this safety net.

We are very pleased to be here because HRSA really is about access to care, both trying to make sure that people can get into the health care system as well as to reduce the racial disparities.

You have already alluded to the increasing number of people who are uninsured, which is a real problem. I want to run through the three programs, and then I will look forward to your questions.

The first is the CAP program. This is a program that is yet to be. We have the request for applications out on the street. We have $25 million, and we anticipate funding about 20 to 30 projects, and we already have application requests for 1,900. So we are going to have a huge demand, and I think this is a reflection both of the need out there as well as the interest in this area. We plan to provide a lot of flexibility around the kinds of grants we fund. We will absolutely require some things like collaboration and sustainability and leveraging of resources. So this is going to be an interesting program that we look forward to getting in place.

The second program I want to talk about is the National Health Service Corps. This program is one that in my opinion, although it has been around for 25 years, still has a huge, huge untapped potential to provide health professionals across the country. The Council on Graduate Medical Education said that we may indeed be producing too many physicians, but that they are not the right kind in the right places, and they do not look like the communities they are trying to serve. Those are things that we think we can cure with the National Health Service Corps.

We have Corps physicians in each State, but I will tell you that, as you have already alluded to, we are only funding 12 percent of the need. We have a huge pent-up demand for Corps physicians and other practitioners. Sixty percent of our Corps providers serve in rural communities, and most of them stay in service, if not in that community, in another community. So we feel like we have a good track record. We are serving in communities where people often will not go, some even in my home town in the rural Mississippi Delta.

So we look forward to talking more with you about the National Health Service Corps.

Finally, the Consolidated Health Centers. We fund right now some 700-plus centers that have over 3,000 sites. We are now serving, combined with the National Health Service Corps and with community health centers, somewhere around 11 to 12 million people. Again, this is against a backdrop of about 44 million people that we know are in underserved areas. So again, there is a huge unmet need.

We are only funding about 20 percent of application for health centers each year, even with the $100 million that Congress has been gracious enough to give us each year for the last couple of years. Our health centers are generally in areas where care is not available. We also know, Senator, that we make a difference. In my opinion, we provide better care than many other providers. The people who come to our centers are high-risk from an income standpoint and for a lot of other reasons. We know that they get mammograms more often than women in the general population. We know that people with high blood pressure are more commonly controlled. We know that Medicaid patients who come to health centers versus those who do not have fewer hospitalizations.

We have a lot of data, and we feel like we can not only tell you that we are in the right places, but that apparently, we are doing

the right things, and we feel like we are making a difference in many of the health conditions that face this Nation. Also, approximately two-thirds of the people that we serve in health centers are minorities.

We also fund Health Care for the Homeless, a huge and growing problem, and migrant health centers. Again, we have an increasing problem in migrant health care in this country, a problem where people lose Medicaid eligibility when they move across States.

So again, we are really proud of both the National Health Service Corps and the Community Health Centers and the other health centers that we fund and what they do. We see them in many ways as the linchpin of the CAP program. They are going to be a part of that. I think the strength of the CAP program is that it is going to involve everybody, we hope, from the public hospitals, other groups, inpatient, outpatient, tertiary care, primary care. What we hope to do with the CAP program is to use our Community Health Centers, our National Health Service Corps, and our other grantees to really weave together what we hope will be a stronger system for every community to make sure that people who fall between Medicaid and private insurance have access to care.

I am going to stop here, and I look forward to your questions.

Senator FRIST. Thank you, Dr. Fox.

[The prepared statement of Dr. Fox may be found in additional material.]

Senator FRIST. Dr. Heinrich, welcome.

Ms. HEINRICH. Thank you.

I am pleased to be here today as you discuss the Federal safety net programs intended to improve access to medically-underserved populations.

My statement focuses on the Community Migrant Health Center Program and the National Health Service Corps. As you noted, my comments on the centers program is based on our report on health centers being released today at the request of you and Senator Jeffords.

Community Migrant Health Centers have offered primary and preventive health services, along with enabling services such as transportation to appointments, since they were established in the sixties. The number of centers has remained stable in recent years, while the number of persons receiving care has increased.

However, centers face many pressures from changes in the health care market, such as the increased number of uninsured patients and competition for Medicaid patients. According to HRSA, about 40 percent of the overall funded centers are doing well, are maintaining sufficient staff capacity and serving a growing number of patients. About 50 percent are experiencing some operational problems, and 10 percent are struggling.

Centers have taken steps to respond to the market changes, and if they have, they are more likely to succeed. Some try to compete for patients and improve operations by forming partnerships and networks. This does allow them to share expertise and resources, such as information systems, and control costs.

Addressing the growth of managed care is another critical factor. Some centers contract with managed care organizations; others have actually become managed care organizations themselves. Suc-

cessful centers know how to attract patients with diverse payment sources, including private pay. They also pursue funding from private donations, foundations, and local governments.

HRSA plays a critical role in maintaining the viability of the centers. The grants it provides are a major source of revenue. It also plays a role in overseeing centers and providing technical assistance. To evaluate overall performance of centers, HRSA each year collects administrative, demographic, financial and utilization data on each center. This information, however, has limitations for monitoring and evaluating performance. For example, the financial data cannot provide an accurate indication of an individual center's status because costs are reported on an accrual basis while revenues are reported on a cash basis. We have recommended that HRSA take steps to improve the quality, accuracy, and timeliness of the data to facilitate its oversight and assistance to centers.

Let me now turn to the National Health Service Corps. At the end of fiscal year 1999, the Corps had 2,526 physicians, dentists, nurse practitioners and other providers in shortage areas. Each year, the Corps receives many more requests from communities for health professionals than it can meet. As a result of this challenge to use resources efficiently, we have four suggests in that regard.

First, we suggest that Congress consider modifying the current requirements regarding the distribution of funds between scholarships and loans. Currently, scholarships receive at least 40 percent of the funding. The loan repayment program costs less; recipients are more likely to complete their service obligations, and they are also more likely to continue practicing in the underserved community.

This is not to say that the scholarship program should be eliminated. In fact, it should be used more effectively to direct recipients to the neediest communities.

Second, HRSA needs to improve the designation of shortage areas. Over the past 5 years, we have reported on a number of problems with the process for determining whether an area is a health professions shortage area.

In addition to problems with timeliness and quality of the data used, we found that the approach does not count providers already working in shortage areas, such as nurse practitioners. As a result, the current system tends to overstate the need for more providers.

Third, it is critical that the Corps implement an effective system for placing providers in shortage areas so that more areas receive placements rather than allowing some areas to receive multiple placements while others have none.

Underserved communities are now frequently turning to another method of obtaining physicians—extending the J-1 visa of non-U.S. citizens who have just completed their graduate medical education. Visa waivers have become so numerous that they now surpass the number of Corps physicians in shortage areas. This sizable domestic placement effort is rudderless. No agency has responsibility for oversight or ensuring that placement efforts are coordinated.

Our final suggestion, then, is for coordination of the visa and Corps programs. First, we should clarify how the use of J-1 visas fits into the overall Federal Government strategy for addressing underservice. This should include determining the size of the pro-

gram and establishing how it will be coordinated with other Federal programs.

Second, I think we should designate leadership responsibility for managing the visa activity for physicians as a distinct program.

In conclusion, our work has shown that while the Community Health Center Program and the Corps have provided valuable services to vulnerable populations, steps should be taken to make them more effective.

At the same time, we would like to point out an overarching issue that our work has consistently identified. That is that the HHS system for identifying underservice needs immediate attention. We believe that HHS needs to gather more consistent and reliable information on the changing needs for service in underserved communities. Until then, determining whether our Federal resources are appropriately targeted to communities of greatest need and measuring their impact will remain problematic.

Mr. Chairman and members of the committee, this concludes my prepared statement. I would be happy to respond to any questions that you or other members of the subcommittee may have.

[The prepared statement of Ms. Heinrich may be found in additional material.]

Senator FRIST. Thank you both. I appreciate you both keeping your oral comments fairly short so we can go through questions and answers. Your testimonies are very well-written and outline some of the points which I would like to address as we go forward.

Dr. Heinrich, the report is very good. I had the opportunity last night to go through and review the report, and I appreciate it. It is a lot of work. I do recommend it to my colleagues on both the subcommittee and the entire committee to obtain a complete and full understanding of Community Health Centers and the changing environment that we all know is challenging and something that we must respond to.

Dr. Fox, if we look at funding for NHSC, since 1990, it has increased dramatically, but over the last several years, it has been relatively flat. This year, the administration's budget makes on request for a substantial funding increase, although it seems apparent, as I mentioned in my opening statement and you reinforced, with the 12 percent figure, only 12 percent of the need for NHCS providers being met.

This whole area of funding is something that I want to address and share with my colleagues, especially as we reauthorize this program. As I read through your testimony, it does not reflect any recommendation for funding increases for this program. Could you elaborate on the administration's position on this and its relevance in assuring the needs of the uninsured and medically underserved population through the NHSC program? The question brings to mind whether no increase in at least requested funding means that we have adequate resources already being placed.

Dr. FOX. Mr. Chairman, we have terribly inadequate resources, and I hesitate to use the analogy with organs, since it is nice that we do not have that as our primary topic of discussion today, but it is somewhat like the organ problem in that if we had enough organs, we would not be having the discussion that we are having.

Part of the dilemma with the Corps and with the issue that Dr. Heinrich discussed is that we do not have nearly enough Corps providers available. It has been fairly static, as you have noted. We are only serving 12 percent of the need overall. If you look at dental health and mental health, we are only serving about 6 percent of the need in each of those areas.

We could actually, in my opinion, with the Corps go a long way toward solving the problems of communities, because we have people waiting to serve in the Corps. We only fund 15 percent of our scholarship requests—15 percent. These are the people who ask to be funded if we had the money. We only fund about 40 to 45 percent of the loan requests. The administration felt, because of a lot of priorities, that there was not going to be a request for increased funding in this program, but it does not reflect the lack of need or demand.

Senator FRIST. Thank you. That is what I had expected, but I wanted to make it clear, because if you look at these funding curves, it is very dramatic, the increases and then the flattening that we have had. I understand the competing priorities, and one purpose of our reauthorization is to reassess those competing priorities.

Dr. FOX. If I could add one other thing that I forgot to mention in my opening comments, which impacts on the real inadequacy of the current funding of the Corps, that is the tax liability issue. The Corps funding has been flat in the face of both an increasing number of uninsured and the increased demand for people to get into the Corps. But we have actually been able to fund fewer Corps positions because of the tax liability issue, where now, we are having to pay either the scholars, or they are having to pay tax liability on their scholarships, and for the loan repayers, we are actually adding a payment onto their loan repayment to help cover the tax liability, which obviously reduces the number of loans that we can make.

So we have in a sense a double whammy, and we hope that that can be addressed in the reauthorization, because it is a huge problem.

Senator FRIST. Thank you very much. That is very important, and as I travel around Tennessee and other areas, it is a problem that people bring to my attention, so I appreciate you mentioning it.

Dr. Heinrich, in your testimony, both in your written and your oral testimony, you talk about scholarship and loan repayment and conclude that loan repayment is a better approach, but you qualify it by saying that scholarships are important as well. Could you elaborate just a little bit further on that? I know you touched on it in your oral testimony, but could you describe a little more the recommendations you have highlighted that would affect each of those, and the comparative value?

Ms. HEINRICH. Yes. In our analysis, we found that the loan repayment program for 1999, for example, would cost the recipient approximately half of what a scholarship would cost. Part of that is because you have the opportunity with a loan repayment recipient to immediately place that person, and with a scholarship program, you have an individual, and therefore, your money, tied up

in the pipeline for the extent of their training, which may be a short as 2 years for a nurse practitioner, or it can be 5 years, 7 years, for a physician.

Senator FRIST. Thank you.

Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman. I am very pleased that we are having this hearing, although I must say that I get discouraged when I hear some of the facts and know that there is so much more that we need to do and should do. So hopefully, we are not too late, because the budget, as you know, is presently being put together. I am deeply concerned about the testimony as to the need versus the ability to supply for that need.

I understand that the National Health Service Corps Program currently has more than 2,500 providers in underserved areas caring for more than 4 million people. This is the largest measure of its success.

Another measure is the number of physicians and other providers who stay in these underserved areas after their service obligation period is over, which to me is somewhat amazing. As you know, Vermont has a very high percentage of rural population overall. I would like to know what impact the National Health Service Corps has had on it. I your testimony, you said that 60 percent serve at least 4 additional years. In Vermont, I think they stay even longer.

Dr. Fox, I wonder if you could comment on that?

Dr. FOX. Senator, you are exactly right. We know that even if the providers in the Corps do not stay in the community they are originally assigned to, most of those providers even 4 or 5 years out are serving somewhere in an underserved community. In fact, in your State of Vermont since 1972, around 32 of 70 Corps providers are still serving in your State. So you have almost half in a period of 25 years still serving in your State.

We do not do that well everywhere, but I think we certainly work hard to try to make sure that we do everything from an incentive standpoint to get people to say.

But I have to say also on the scholarships, if I could swing back to a comment on Dr. Heinrich's recommendations, that one of the values of the scholarship program—and it is a higher-cost program—but we feel like we have a little more leverage to get scholarship recipients into the communities where we might not be able to get a loan repayer. Obviously, they may not stay, or as many of them may not stay, but we think it is certainly one of the advantages of the scholarship program.

So we think we have good numbers overall, and we are working to try to increase them. There are only about 3 percent total defaulters in the program, which I think is a good rate overall. So again, I think the statistics in general are good for the Corps. We are trying to improve them, but to be honest, my position is that even if we never had one person who stayed, they are serving that community while they are there. The flip side is that we are going to do everything we can to try to look for incentives to help them stay and to place them appropriately so we match them with the community that is not only underserved but hopefully one where they will want to stay when their commitment is over.

Senator JEFFORDS. Do you have any information about providers in shortage areas who started out as National Service Corps volunteers earlier in their careers and then elected to stay after the obligation period had ended?

Dr. FOX. We actually do, and again, we know that more than 50 percent of them stay in a shortage area or underserved area somewhere. We have actually polled over the last couple of years National Health Service Corps alumni, and we know that the majority, more than half, will stay somewhere in an underserved area, which I think speaks to the program overall.

Senator JEFFORDS. How are they compensated?

Dr. FOX. They are paid by whoever hires them. With the scholarship-alone program, obviously, that is forgiven over time as they fulfill their service. But they are hired by community health centers, by rural health clinics and by others in the community, and their salary is actually paid by the entity that hires them.

Senator JEFFORDS. Prior to 1998, the IRS withheld taxes from National Health Service Corps living stipends. In 1998, they began to withhold taxes on scholarships as well. I introduced a bill last Congress to allow National Health Service Corps scholars to receive their scholarships tax-free, and I reintroduced it in this Congress as Senate bill 288. Last Congress, we passed the bill twice, and both bills were vetoed by the President. We passed it again this year as part of the Education Savings Account Bill, which I also expect to be vetoed.

What have been the effects of the IRS decision to withhold taxes from the National Health Service Corps scholarships?

Dr. FOX. First let me say we appreciate your support and that of others, Senator, to try to address this issue. It is a huge problem for us. One, we feel like with the taxes being taken out of both the scholarships and the loans now, it makes them less attractive. It also gives us less money to put out there, and it reduces the number of people we are able to place. Quite frankly, I think it is almost robbing Peter to pay Paul. So we would love to see this fixed. We would like to see it fixed either as a part of the reauthorization or as a separate bill, or attached to some other bill, but it definitely needs to be fixed.

Senator JEFFORDS. We will be pushing, and hopefully, we can get the President to sign it.

Dr. FOX. Thank you.

Senator JEFFORDS. Dr. Fox, the Consolidated Health Centers Program has enjoyed considerable bipartisan support. I am pleased that we were able to achieve $100 million increases in each of the past 2 years. As we consider an even larger increase this year, I would like to know if you could estimate the percent of worthy applications that you were able to fund this year's allocation versus a percentage of those health centers that had legitimate needs and did not receive funding.

Dr. FOX. I would be pleased to. Again, we appreciate the bipartisan support that Congress showed in the appropriations for the health centers for the last couple of years. We funded approximately 20 percent of the applications. We are going to be funding for the coming year beginning October 1—and I think we actually may have done it for this year; some of the approved are not fund-

ed from the previous year—but I would say overall, if you look at a per-year basis, we have funded about 20 percent. Of the $100 million Congress has given us, we have used about $40 million to shore up existing centers, which some of the appropriations language instructed us to do and we wanted to do, and then we have taken the rest of the money both for new starts and for other types of support for the centers, but we have been able to fund about 50 new starts, or probably 20 percent of our total applicants. So we have much more in the way of applications than we are able to fund.

Senator JEFFORDS. Thank you.

Senator FRIST. Managed care, capitated payments, changing environment—could both of you comment on the impact, both currently and in the future, that the move toward more capitated payments does to our community health center, the delivery systems that we are talking about today? The trend is likely to continue. In some areas, Medicare has gone too far, and we will try to rein it back in to make sure that it is appropriate coordination in management of care and not inappropriate coordination in management of care.

But how do the community health centers succeed in a market that is a little bit easier to define, I think, in the insured market where capitation is a trend that will likely continue? Could both of you comment on that, please?

Ms. HEINRICH. What we are seeing is a lot of variability in how centers are able to respond to these market forces. I was rather impressed to see the variation in the centers themselves, so you have some very large centers such as the one in Denver, CO, and then you have others that are very small and have a smaller geographical area which they are covering. But their mission also is to provide services to the uninsured and Medicaid populations, and when you have the States changing policies in terms of how they are going to reimburse Medicaid, I think it makes it very difficult for the centers to operate in a fiscally solvent way.

The other thing that we found that was quite interesting was that the centers have various systems in place so they can actually determine what their true costs are, and currently, most of their systems seem to be on an encounter basis, but it does not seem that many of them have the ability to actually understand their cost for a patient for an episode of care, for example.

Most of the centers are providing services that are truly primary care and preventive—care to pregnant women, care to children—and I think there is a lot of variability in how those services are actually reimbursed.

Senator FRIST. Dr. Fox?

Dr. FOX. Senator, I think we have provided a tremendous amount of technical assistance to the centers, ranging from just general managerial training to actually going in and having somebody from an HMO help them negotiate a contract locally. But it has been difficult for the centers, and I think the amount of money that we put in—we send a dual message. We say, one, go out there and earn your keep and generate revenue, and then, by the way, we want you to see everybody who has no way to pay. About 40 percent of people who come into the centers have no insurance, and

that number has grown. The increase since 1990 has been twice the national increase. So we have had a huge, disproportionately large increase in uninsured coming to the centers. So our money really fills the gap—the money that you provide. Nationally, about 26 percent of centers' funding is from the Congress, from the CHC money.

If you then look by State—and Jan is right; we do not have a lot of center-specific information, but we can tell you by State—the Medicaid policies in the States often will be reflected in how much money we have to put in to help a center survive. If the national average is 26 percent—for instance, in Tennessee for TennCare, it is 41 percent, and we have to put in 41 percent statewide to all the centers in Tennessee for them to make a go of it as opposed to 26 percent nationwide. We know that Medicaid revenues per client nationally have been declining. We know that Medicaid revenues as a percent of total revenues have been declining, and we know that particularly 1115 waiver States, we have a special problem, because in those States, maybe the State does not make supplemental payments—they make what are called cost-related payments, and cost-related can mean just about anything—Congress has slowed the glide path on the decrease in the costs for reimbursement—but in those 1115 States, cost-related could mean that we give you 45 percent or 50 percent.

Senator FRIST. How many 1115 States are there now?

Dr. FOX. I do not know. We can get that number for you, but it is a fair number. Some of them—it is not a universal problem—there are some 1115 States that are paying better than others, so it is not all——

Senator FRIST. That is an aggregate.

Dr. FOX. Exactly. It is everything from A to Z. But there is more of a problem in the 1115 States than in general. I would say that in the evolution of managed care, we are seeing a decline per recipient in Medicaid revenue at the same time that our numbers of uninsured have gone up. And we have used about 40 percent of the money each year that you have given us to help fill that gap. It is a real problem.

Senator FRIST. Dr. Heinrich, do you want to comment further on that?

Ms. HEINRICH. Only to say that the bottom line here is that we are expecting these centers to be small businesses and to bring in revenues from a variety of sources so that they indeed can meet their mission of providing services to very low-income and uninsured, high-risk populations.

Senator FRIST. Dr. Heinrich, you mentioned in your testimony the importance of identifying the needs of the uninsured and the medically underserved, and the inability of HHS systems to do that adequately today. In order to target resources, you clearly need to be able to define well where the unmet needs are. Could you elaborate on your findings as well as any recommendations that HHS should be taking to better identify those needs and track those unmet needs and the program impact?

Ms. HEINRICH. Yes, let me try. Besides having a system for identifying the health profession shortage areas, we also have a system for identifying the medically underserved areas. Different compo-

nents go into that. Some of these approaches look at broad county areas, larger regions of a State. Some focus on populations, and some focus on facilities. You therefore have some urban areas where we see neighborhoods that are underserved, and then you have the opposite, with very rural areas where people have to travel long distances.

What we are saying is that the existing system does not make a great deal of sense. It is very broad and very hard within that to really target the people who really need the services. What we are also saying is that HHS really does need to update and revise the system and have it based on current data.

As it stands now, I think that HRSA does update the health professions shortage areas, but there is no requirement for the update of the medically underserved areas.

The other thing that is occurring here is that this designation in a community is also tied to other Federal funding programs which then allow providers to get the cost-based reimbursement. That seems to be further complicating progress in updating and revising these shortage areas.

To the credit of HRSA, they did have a draft proposal that has been put forward in the Federal Register, and there has been comment, and it is my understanding that you are now in the process of continuing to work on that.

Senator FRIST. Dr. Fox, do you want to comment on that?

Dr. FOX. Sure, Senator. One, let me say that the MUA-HPSA designation that was put together initially was never meant to be used for HCFA payments for rural health clinics. A lot of things have been tagged onto it over time that were not necessarily originally intended, and it certainly was not set up for that.

We have taken the GAO's recommendations, for instance, in things like counting mid-level practitioners, nurse practitioners, and physicians' assistants as a part of the mix and put out a revised regulation. It is quite complicated, more complicated than I thought it was when I first came to HRSA. We put that regulation out for public comment, and we received a lot of comment and a lot of concern, particularly from the rural health community, about potential areas that were going to be de-designated.

One of the dilemmas for us is that if we found mid-level practitioners, which I think we should, in the designation, and if we use a lower physician-to-population ratio—the agency proposed to use one to 3,500, and OMB in the final regulation had us put in one to 2,000—what we ended up with was a bunch of areas that were going to be de-designated. Quite frankly, we think that one to 2,000 is more reasonable, and one to 3,500, we do not think is a good ratio. So I think it is both an issue of what you count, what the ratio is going to be, and the other factors.

As we speak, we are working with a number of different centers to run some data to see how it is going to fall out. We have met with virtually all the constituency groups since the first NPRM was put out, and we plan to issue another NPRM probably in the fall. Again, we want to take comment, and we want this to be a new revised designation that works for communities. We do not want it to be disruptive. We want it to be reflective. We had built in a number of provisions that allow—for instance, if a State has local

data that is more current than ours, they can submit it, and we can use it. I think there are a number of things like that that are quite positive, and we will be putting that out again this fall.

Senator FRIST. Thank you.

I now turn to the ranking member, Senator Kennedy.

Senator KENNEDY. Thank you.

I would like to ask that my full statement be put in the record.

Senator FRIST. Without objection.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

I commend the Chairman for holding this timely hearing on the role of safety net providers. It is difficult to imagine what health care in the United States would be like today without the health centers, the public hospitals, the National Health Service Corps members, and many others who catch those who might otherwise fall through the cracks of our health care system.

Federal support is essential to recruit and train the primary care professionals who provide quality health care to vulnerable populations in rural and urban areas of the country. More than 21,000 dedicated health professionals have served with the National Health Service Corps since it began a quarter century ago, and I commend them for their commitment. I also commend the health centers and hospitals across the country that provide care to those at greatest risk of illness because of poverty, malnutrition, occupational exposures, language barriers, and inadequate or non-existent housing.

Community, migrant, homeless and public housing health centers have demonstrated their ability to provide cost effective care, reduce infant mortality, and lower hospital admissions and length of stays. Every dollar invested in these health centers saves $7 in costs under Medicare, Medicaid, and private insurance, because of the lower use of specialty care, in-patient care, and unnecessary hospital emergency room visits.

Nearly 90 percent of the patients served by these health centers have incomes at or below 200 percent of poverty. A third of all uninsured health center patients are children. These community-based health centers know their patients, understand their concerns and speak their language.

The availability of physicians in rural and urban underserved areas continues to be a problem. More physicians leave these areas each year than the National Health Service Corps, at its current level, can replace. In fact, the consolidated health centers and the Corps are the only federal programs specifically designed to address problems directly related to access to health care, rather than health insurance. We must do all we can to strengthen their role. I continue to believe that our overall goal is to achieve universal health insurance coverage for all our citizens. But we must at the very least do more to see that all patients—regardless of income, health status, or other factors—have access to health care.

I look forward to hearing today about the Administration's new Community Access Program. Expanding access to the uninsured by improving coordination among existing safety net programs is a promising idea and deserves our support.

The number of uninsured patients treated at health centers has risen substantially in the past decade. Federal support has not kept pace with the rising number of uninsured Americans. The growth of managed care in Medicaid has brought significant new challenges for community health centers and other safety net programs and providers. The safety net is fraying at a time when we need it most. Congress should do everything in its power to assure the success of these vital programs.

In Massachusetts and every other state, safety net programs reduce barriers to health care by making clinicians available in the community they serve. Today, we'll hear testimony from Dr. Robert Taube. His Boston Health Care for the Homeless Program serves 7,000 homeless persons at over 50 locations in the Boston area. His staff includes two internists who were originally recruited through the National Health Service Corps, and who have stayed on and continue to serve this vulnerable population.

More than a quarter of a million people in Massachusetts rely on care from health centers at 118 sites. The center in Lawrence is an excellent example of the vital role of these safety nets. It is the only source of primary care for the residents of this low-income minority community. Since 1980, the Greater Lawrence Family Health Center has reduced infant mortality rates dramatically—from 15 per 1,000—below the national average.

The health center has increased immunization rates and reduced hospitalizations as a result of better preventive care. As the only certified family practice residency training program in the area, the Lawrence center is preparing physicians for future community-based work. Dr. Joel Gorn, a pediatrician who trained at the Lawrence center, is a recent success story. He has set up practice in Lawrence and is committed to staying in the community. He is living in the city and has even helped establish a community garden.

I look forward to working with the Chairman and our colleagues to close the gap for unmet health needs of communities across the country. Through timely assistance, we can strengthen all these safety net programs. The health care system has changed significantly since the last reauthorization of these programs, but the needs are still large. Our communities deserve the last reauthorization of these programs, but the needs are still large. Our communities deserve reliable safety net programs that provide high quality health care, and Congress should see that they have them.

Senator KENNEDY. I do want to thank you, Mr. Chairman, Senator Jeffords, Senator Dodd, Senator Reed and others on the committee for holding this hearing and for the strong support that you have given for the programs and the fact that they are moving along. We are in a difficult year, so to speak, both because of the brevity and the intensity of the year, and hopefully, these efforts will continue and expand. They are enormously important, for the reasons that you know, and I think we have heard excellent testimony now and will hear more later.

I want to just reiterate again my strong support. I can remember that Warren Magnusen was one of the first supporters of the Health Service Corps. It was different then—it was effectively grants—and now it is loan repayment, and it works pretty well. But those numbers have been absolutely stabilized over the years

and have not increased. That shows what happens with level funding. We still have 2,500, and we had 2,500—I will ask staff to correct me—but I think 20 or 25 years ago. The problems in terms of need have expanded and are expanding. There are increasing numbers of people without health insurance, and increasing complexity of the challenges out there in terms of underserved communities, and the all problems of substance abuse, AIDS, violence and abuse in the communities put an incredible burden on all of this—language and cultural changes—and on the health care centers. I take note from the GAO that the States are not doing their share in the hope that HCFA will be more responsive and that the States will do more. They are doing well—my State is doing very well, and we have very, very effective programs in terms of the delivery system. But even with the increase in funding which has been noted, there are increasing numbers of people going to these centers who do not have health insurance, and this number will increase, I daresay, unfortunately, and we are attempting to deal with that.

So we will work very closely with you, Mr. Chairman, both on the funding and urging, hopefully, some expansion.

Let me ask you just one question, because time is moving on. How will the CAP program complement rather than compete with the Health Centers Program? What is your response to that?

Dr. FOX. Senator, we see the health centers and the National Health Service Corps as the linchpin of many of the CAP program. It is certainly going to go beyond that. One thing we are going to do, for instance, is when we fund a grant under the CAP program, the first thing we are going to do is find all the HRSA grantees within that area and link them up. Second, we expect health centers to be a part of many of the CAP proposals that are going to get funded. It is certainly going to include hospitals and other providers, but the health centers are part of that. In fact, the "100 Percent Access/Zero Percent Disparity campaign" that the Bureau of Primary Health Care has had underway over the last couple of years to me is a very analogous campaign to what Congress has passed with the CAP program. We see them really working together hand-in-glove. I do not see that there is any disconnect here.

Senator KENNEDY. We will watch it, because there are many pressures also in terms of the hospitals, particularly community hospitals. There are enormous tensions, as we have seen in my own State and in neighboring States, with what is happening with the large HMOs leaving areas. We are all for linking people up, but I think we also have to recognize our responsibility for making sure that what we have out there is adequately funded and that our institutions are working and working effectively. But I look forward to reading your testimony more closely.

I thank the chair.

Senator FRIST. Thank you.

Senator Dodd?

Senator DODD. Thank you very much, Mr. Chairman, and let me add my voice as well to your leadership on this. I appreciate it immensely. These are tremendously valuable programs which have been critical to so many of our constituents, almost 8 million across the country, who benefit as a result of this wonderful series of programs that reach out and touch people who otherwise would be ab-

solutely denied the opportunity to have any kind of health care coverage at all.

I would ask as well that a statement be included in the record, if I could.

Senator FRIST. Without objection.

Senator DODD. I would just point out that, I guess like all of us, I make a point of visiting the community health centers in my State, and I was recently at the center in Bridgeport, CT, which has served that community, Mr. Chairman, for 25 years. It has been a remarkable facility. Most of my major cities have had these programs for some time, and they have really worked very, very well.

It is interesting to note that people do not just go there because they have to; they go there because they want to. This is something that gets lost, and I think it is worthwhile nothing that in many cases, it is the one place where not only can you get health care, but also where someone understands the language you speak. I cannot tell you what a difference that makes when you walk in if you are an immigrant family that has just arrived in this country.

In Bridgeport, CT, I recently spoke at one of our senior high schools, where there were about 150 kids, and among juniors and seniors, there were 43 different languages spoken by those students in that one class—all first-generation, some second-generation, but mostly first-generation. And that health care facility is a place where those 43 different languages can go and someone there will understand what they are talking about. That is extremely valuable, the sense that you are being cared for and that someone really wants to help. There is the issue of transportation, so you can get there. That is not an insignificant hurdle for people who are poor and are trying to get around. Many poor people do not own cars. Many of them do not live in areas where public transportation is available.

So there is a lot more to this than just they "have to be there"; people want to be there. In fact, in anticipation of the hearing, I received a whole bunch of letters from several of the community health service centers in my State, Mr. Chairman, and some of them are just very touching. Some are written in a broken combination of English/Spanish, not great handwriting. For example, one reads, in a very broken hand: "Senator Dodd, please do not close my health center. Medicino esta qui." It is just touching.

Another one: "I am a 16-year-old patient at CHS. I have been coming here since I was little. I have asthma, and they have really helped me with my asthma problems. If they were to close down, I would really be upset, because CHS is where I have been treated all my life."

Again, some of them are completely in Spanish, as is this one is from Rosa de Jesus. [Reads in Spanish.] It is very simple Spanish, but you get the point.

So these centers are tremendously valuable to these people. I might ask, Mr. Chairman, that these little notes be included as part of our transcript, because we hear from the professionals, as we should, but every now and then, it is nice to know that we hear from people who are actually served by these facilities as well, in their own simple language about what a difference they can make.

Senator FRIST. Without objection, they will be made a part of the record.

Senator DODD. Thank you, Mr. Chairman.

[The prepared statement of Senator Dodd and letters were not received in time for publication.]

Senator DODD. Let me ask just a couple of quick questions if I can, Dr. Fox, that come to mind. There is a community development aspect to this as well. We have a tendency to focus on this in health terms, and we should, obviously, but I wonder if you might comment on what have been the unanticipated beneficial consequences of these community health services programs in communities beyond serving the medical needs of people that you could share with us.

Dr. FOX. Let me make a general comment and then a specific one. The general comment is that in most communities, certainly the rural communities, the health care industry is second only to education in employment and in economic importance to the community.

Specifically for community health centers, Senator Dodd, we estimate that the health centers provide 50,000 full-time jobs in communities and 75,000 total jobs, some of them part-time, some full-time. So it is a tremendous employment engine. We know that it puts dollars into the community. We have about 8,000 clinicians nationwide, but—either part-time or full-time—some 75,000 people who are employed and working in communities, earning salaries, spending their money in the communities, that we think provide a lot of positive benefits that go beyond the direct health care.

Senator DODD. That is very positive. Maybe you could even include some specific examples—I will not ask you now, but for the record—on exactly how that has worked beyond just the general concept. I think that might be worthwhile.

Dr. FOX. We would be glad to.

Senator DODD. Second—and I know I am preaching to the choir here, not only as I say this in front of my colleagues, but also to you as a witness here this morning—all of us understand—no one understands this better than the chairman understands this—that if you catch a child early with a potential health care problems and treat it before it becomes more serious, the benefits of that are just obvious. That is just common sense. A lot of us took a long time to understand that. Doctors and health care providers understood it from their first days in medical school, I guess.

I know that we serve schools, school-based health clinics, under the Community Health Services Program, but with a very, very small amount—$6 million in 23 States. I know this can be controversial to some degree, but obviously, providing services for children on a school-based basis can be tremendously beneficial. I wonder if you might comment on the benefits of that approach as you see them and whether you believe there is a need to expand the Federal support for school-based health centers.

Dr. FOX. Certainly. First, as a pediatrician, Senator, let me say that I agree with your comments. I think that the early intervention kinds of things we can do for kids certainly make a huge difference, and not just in fiscal but in mental health.

I think we have a real opportunity with the SCHIP program to fund dental health, mental health, in communities. We have the ability to do that, which is something that we could not have done 5 years ago. And I think one of the things that we are trying to do is encourage States that are not fully enriching their programs with mental health and dental health benefits to do that under SCHIP.

Second, we have been able with the money that the Congress, with bipartisan support which has been fantastic, has provided us, to double the number of school health clinics over the last couple years. We are still not anywhere close to what we need to be funding.

One of the things we are going to do—and we are going to try this, and it is a little entrepreneurial and a little out-of-the-box for us—but one of the things we want to do is take some of our community health center money and some of our maternal and child health money, and we want to go in and find communities where the majority of families in the school are under 200 percent of the Federal poverty level and are perhaps not in a managed care situation where we cannot get a carve-out for school health, and put some up-front money into the schools from our two bureaus—we want to do this over the next year—and see if we can help them not only set up a school health system but if we can help them set up billing mechanisms, give them a short-term grant, let them know on the front end that this money is for not more than 24 months at the absolute most, and see what percent of that center can they provide in revenue to support, and can we get down to where we are left with only 10 or 20 percent that we have to fund out of our grants, and then we can take our money and move it somewhere else.

I do not know if it is going to work, but it is one thing that we are going to try that is a little different to see if we cannot seed more school health centers.

School health to me is absolutely the way to go. One of the advantages of doing it with the community health centers and with the health care provider is that they are hooked up with somebody who knows how to bill, who can provide continuing education for the providers, who can provide the referral base. It is a captive audience, and we ought to use it not only for care but for enrollment.

So we agree with you that it is important, number one, and number two, in addition to funding some additional sites out of the money you have given us, we are going to try to do some things beyond that to see if we cannot get more school health centers going.

Senator DODD. That is very, very good news, and I would like to be kept abreast—and I am sure the committee would—of how that is progressing.

The red light is one, but I just want to ask one last, quick question of you, Dr. Heinrich, if I can. One of the recommendations that the GAO makes is that the program take into account those physicians placed in underserved areas under the J-1 visa waiver program. As I understand it, a physician who is not a U.S. citizen can stay in the United States for additional years beyond the expiration of his or her visa if they agree to practice in an underserved area,

and that the number of physicians who have taken these waivers now surpasses the number of Corps volunteers.

I wonder if you could share with us what your thoughts are on how best to coordinate these two different but similar programs, and do you propose that the Federal oversight of the J-1 visa waiver program be replaced within HHS?

Ms. HEINRICH. Yes, you are correct that we do say that we feel that the J-1 visa program as it stands now should be coordinated in some fashion with the National Health Service Corps Program. We stop short of saying where it should be, but I can assure you that now, there is not a Federal agency that is keeping track—there is not tracking at the State level—so there is no oversight of what is happening with the J-1 visa physicians or even how long they are staying in the country, for that matter, because when we did our preliminary work here, we found that even the INS is not really tracking this in any systematic way.

In terms of the coordination, I can give you a very concrete example of what happens. I will take the State of Maine, which has 40 areas designated as underserved in that State. Within that, 21 positions are needed in the State of Maine. The National Health Service Corps is providing 27 positions. The State waiver program has 25, and the U.S. Department of Agriculture has another five. So that is actually putting the number of people in these shortage areas at 290 percent of what the program says it actually needs. So that is what happens when in fact you do not have the coordination.

Senator DODD. I want to give Dr. Fox a chance to comment, because there are a number of issues around this—and I do not serve on the Judiciary Committee, but others may want to get into this a bit. It is a serious issue.

Dr. Fox, I see you are chafing to respond.

Dr. FOX. Thank you, Senator.

One, we do have as a part of the proposed new regulation around HPSA MUAs to count the J-1 visa docs in addition to the mid-level practitioners. So we are proposing to do that, and that is a change from what we have done in the past.

Second, I do not disagree with Jan. I think there is a need for close coordination. I think that perhaps there is a little more going on at the State level than we anticipate. When I was the health commissioner in Alabama, I was actually responsible for the contract that does the HPSA-MUA stuff for Alabama, and we looked at and worked with the J-1 visa placement as well as National Health Service Corps, and we have those contracts with all 50 States, so I suspect there is a lot of that going on at the local level. It is not necessarily reported, and I think we can do better, but I think there is some coordination going on.

Beyond that issue, we would certainly be pleased to work with the Congress on anything we can do to better coordinate the J-1 visa issue. We need to have the right hand know what the left hand is doing for sure.

Senator DODD. Well, again, this is a big subject matter I suspect, Mr. Chairman, you could hold a separate hearing just on this one issue alone—but a couple of thoughts come to mind just quickly. One, I think it is wonderful, and we are delighted that there are

physicians who are willing to come here and serve in underserved areas—but frankly, there are an awful lot of people out there that I would love to be able to attract into the health provider professions, and one of the reasons they do not do it is because of the exorbitant costs of a health care education. And if we could do a better job of offering these people the kind of reduced educational costs for serving—and I mean real reductions in their costs—I suspect we might end up with a broader spectrum of people who choose this as a career pattern, who will then move into these underserved areas. Again, with all due respect to the J-1 visa-holders, I would prefer to have those jobs go to U.S. citizens who might be thinking about this as a calling or a profession. If you cannot meet the needs, then dip into the J-1 visas. But if makes me uneasy to think that we are running to that solution and denying an awful lot of citizens in this country whom we are going to need as health care providers and professionals in the coming years.

Senator FRIST. We are going to have to move on to our second panel, but this whole issue—Senator Kennedy and I were just talking about the same thing in terms of the J-1 visa—is such a changing issue. When I was practicing medicine before I came to the Senate, I spent a lot of time trying to figure out from a manpower standpoint how to make the visa system work and use it to my advantage. Now I am on this side, and we are trying to figure it out. Clearly, we need to spend a lot more time in terms of the manpower/person power needs and the interrelationship between visas, the GAO report, and the centers.

Senator DODD. I apologize, Mr. Chairman, for taking the time.

Senator FRIST. No—it is actually a very, very important issue that we need to come back and address in various committees.

Senator Jeffords, one final comment, and then we will move on to our second panel.

Senator JEFFORDS. Just a comment on available funds. In 1994, I got included in the Elementary and Secondary Education Act what is now referred to as 21st Century Schools. One of its primary purposes was to try to utilize facilities for health care as well as for education. However, the Secretary had a different view, and we had a hard time getting any of that money used for that purpose.

We are reauthorizing it, and I just want to let you know that we are going to put more emphasis on it and have been working on it with the Secretary. So if you want to grab some funds, just push on the Secretary to make sure that that aspect of the law is better utilized.

Thank you.

Senator FRIST. Thank you.

Let me once again thank the first panel. It is a great report, and we will share it and distribute broadly and appreciate your efforts in that regard.

Dr. Fox, thank you for your leadership in a very important field, one that this committee is committed to. The data, the information, and the recommendations will all be carefully considered as we go through the reauthorization.

Thank you both very much.

Ms. HEINRICH. Thank you.

Dr. FOX. Thank you, Senator.

Senator FRIST. We are going to have a series of votes here shortly, so I do want to move forward with our second panel—I do not want to go too quickly but want to be able to cover all the issues. I will ask the second panel to come forward as I introduce them.

The purpose of the second panel is to look at real life expertise and real life experiences from people who are working within each of these programs.

Dr. Thomas Dean is a general practitioner and the medical director of Horizon Health Care in Wessington Springs, SD. Since 1978, Dr. Dean has been medical director of a network of clinics which currently serves seven rural communities in South Dakota. He served in the National Health Service Corps of the U.S. Public Health Service in Kentucky, and he has served as president of the National Rural Health Association. He received his M.D. with distinction in research from the University of Rochester and completed his residency at the University of Washington. He is testifying today on behalf of the National Rural Health Association.

Mr. Bernard Simmons of Tylertown, MS has been executive director of the Southwest Health Agency for Rural People since 1984. SHARP is a federally-supported community health center that serves more than 5,000 low-income people in rural Southwestern Mississippi. Mr. Simmons is an active member of the National Association of Community Health Centers and has served as board member of the National Rural Health Association. Today he is testifying on behalf of the National Association of Community Health Centers.

Dr. Mary Bufwack of Nashville, TN has been the chief executive officer of United Neighborhood Health Services, a nonprofit group of health centers in middle Tennessee serving poor and underserved residents for the past 11 years. As CEO of United Neighborhood Health Services, she has developed a bilingual health service for Hispanic residents, a special program for diabetic patients, as well as many other programs designed to reach out to specific underserved populations in the community.

In 1993, she was recognized by the Bureau of Primary Health Care for the innovative model of community-based health centers. She has served as president of the Tennessee Primary Care Association, an organization of Tennessee community health centers. Dr. Bufwack received her Ph.D. in anthropology from Washington University in St. Louis.

Dr. Robert Taube of Boston, MA will be introduced by Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman.

It is a pleasure to welcome Dr. Taube to the committee today. Dr. Taube served in the first neighborhood health center out in Columbia Point; that one as well as one in Mississippi were really the great-grandparents of all the neighborhood health centers. He was there at the first one and now continues his work in the area of the homeless and runs I think not only the best program in terms of services to homeless people in the Boston area, but really, a program which I think is a national model.

This has been his life's dedication, and we are delighted to welcome him today.

Senator FRIST. Mr. Larry Gage, from Washington, DC, is a co-founder and president of the National Association of Public Hospitals and Health Systems. In this capacity, Mr. Gage assists America's safety net hospitals by obtaining Medicare and Medicaid payments and by financing improved access to care for uninsured patients. He has previously served as deputy assistant secretary for health legislation in the Federal Department of Health and Human Services and as staff counsel to our Senate Labor and Human Resources Committee. Mr. Gage received his law degree from Columbia.

With that, why don't we proceed in the order in which I introduced you, so we will start with Dr. Dean. Thank you very much, all of you, for being here today.

STATEMENTS OF DR. THOMAS M. DEAN, MEDICAL DIRECTOR, HORIZON HEALTH CARE, WESSINGTON SPRINGS, SD, ON BEHALF OF THE NATIONAL RURAL HEALTH ASSOCIATION; BERNARD SIMMONS, EXECUTIVE DIRECTOR, SOUTHWEST HEALTH AGENCY FOR RURAL PEOPLE, TYLERTOWN, MS, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS; MARY BUFWACK, CHIEF EXECUTIVE OFFICER, UNITED NEIGHBORHOOD HEALTH SERVICES, INC., NASHVILLE, TN; ROBERT L. TAUBE, EXECUTIVE DIRECTOR, BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM, BOSTON, MA, ON BEHALF OF THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL; AND LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, WASHINGTON, DC

Dr. DEAN. Good morning, Senator Frist, members of the subcommittee. As you indicated, my name is Tom Dean, and I am a family physician and have been in practice in Wessington Springs, SD for 21 years.

I am here today on behalf of the National Rural Health Association, and I really want to thank you for the opportunity to testify in support of reauthorization of the National Service Corps, which has had a major impact on our community and on me personally.

Dr. Fox laid out the overview of the Corps, and I would just like to talk a bit about some of my personal experiences with this program. I joined the National Service Corps in 1973, began active service in 1975 in a small community in Southeastern Kentucky, Hyden, KY, and then, in 1978, returned to South Dakota, and since that time have been medical director of a series of small clinics, initially three clinics in Wessington Springs, Woonsocket and Plankinton, and we have subsequently joined with a number of other small clinics, so we now have a network of seven small clinics.

Of the five clinicians hired to start the project that I joined in 1978, three were National Service Corps officers, and I am proud to report that of those three, two of us are still there 21 years later. During those 21 years, we have had five other National Service Corps clinicians and an overall total of four physicians and three mid-level providers. Today, three of our six clinicians have come to us through the National Service Corps.

Our program placed clinicians in two counties which had been without a local source of primary care services for 20 years prior to the start of our program, and since then, over the past 21 years, those two communities have had continuous local access to primary care services, and in one instance, from the same physician's assistant who started there 21 years ago, as I mentioned.

So we are pleased that we have been able to provide a continuous source of primary care services in several small communities.

We serve a low-income, relatively isolated, rural agricultural area with one of the highest proportions of elderly in the State of South Dakota. Since we began, death rates from heart disease and cancer have declined as has the rate of teenage pregnancy. In addition, immunization rates have risen substantially. These changes in health status have been a result of many factors, but I am convinced that the presence of Corps clinicians has been a major contributor to this improvement.

With the help of National Service Corps clinicians, we have been able to develop an integrated rural health care center. Currently, on one location, we have a small hospital, a nursing home, two elderly congregate living apartment complexes, a dentist's office, an optometrist, a home health service, and an office of the country public health nurse, as well as our own clinic—all of this in a town of 1,100 people.

The availability of a consistent source of primary care services has been the base on which this complex has been developed. Our practice is located in an area where it has been extremely difficult to recruit clinicians. If it were not for the Corps, I think I can say with complete sincerity that I do not believe I would be there today.

Over the years, we have used every conceivable available recruiting technique to locate physicians—advertising, professional recruiters, mailings to residents—yet nothing brought us any applicants. The only consistent, effective approach has been through the National Service Corps.

I think our community is not unique in this regard. The reality is that there are many communities across this country where recruiting has been and I think will continue to be a difficult issue.

Over the life of the National Service Corps, much has been made about the issue of retention of Corps clinicians at the sites where they are placed. Critics of the program have used this as the sole criteria for judgment of the success of the program. I would submit that although retention is unquestionably an important goal, it is not the sole determinant of the success of the program. By far the most important measures of the success of the National Service Corps Program is whether underserved communities receive health care that they would not receive through conventional sources. This is clearly the case in our setting, and I believe it is true of thousands of other National Service Corps sites across the country.

I would like to echo some of the comments that were made about the tax issues that were raised earlier—and I understand that that is not the purview of this committee, but it clearly is a real concern that we are using Federal tax dollars to pay Federal taxes, and it just does not seem to be a logical use of our resources.

In conclusion, we live in a time when commercialism and business priorities have come to dominate much of what we do in the caring professions. The National Service Corps, with its emphasis on health and on service, is a wonderful opportunity for young clinicians to experience the rewards of providing care to people who are truly in need. Through that experience, I think they are in a better position to understand the vital role they play in their own professions and the need to maintain a focus on the fundamental values of caring and service which are so easily neglected in today's commercial environment.

I feel deeply that the National Service Corps has played a vital role in developing and sustaining health care in our community. Just as importantly, I think the program contributes greatly to the professional growth of the professionals involved.

On behalf of the National Rural Health Association and other national organizations, I would certainly strongly urge that the National Service Corps be reauthorized and expanded. I truly believe it is a program that has been a major positive force in dealing with the needs of underserved communities.

Thank you very much.

Senator FRIST. Thank you very much, Dr. Dean.

[The prepared statement of Dr. Dean may be found in additional material.]

Senator FRIST. Mr. Simmons?

Mr. SIMMONS. Mr. Chairman, I have prepared a written statement, and I would like to request that it be entered into the record, and I will focus my oral comments to reflect highlights of that statement.

Senator FRIST. It will be made a part of the record.

Mr. SIMMONS. Thank you, Senator.

Mr. Chairman and members of the subcommittee, my name is Bernard Simmons, and I am the executive director of SHARP family care center, also known as the Southwest Health Agency for Rural People in our part of the woods. We are located in Tylertown, MS, a rural community 100 miles south of Jackson, 100 miles north of New Orleans, and 85 miles from the Gulf Coast. We are in the heart of the southwestern part of the State.

I appreciate this opportunity to speak with you on behalf of the National Association of Community Health Centers regarding the work of health centers and other safety net providers in caring for uninsured and underserved people in our rapidly changing health care system and environment.

Health centers today represent more than 35 years of Federal, State, and local investment in primary care for medically underserved populations and communities. Health centers provide a comprehensive range of high-quality preventive and primary health care under one roof in a one-stop caring system.

Each local health center is unique in terms of its range of services and hours of operation. It is a reflection of local decisionmaking at its best at the grassroots level on how best to meet the community's needs and the patients' health car needs.

Health centers are monitored and held accountable for cost-effectiveness, quality of care, and management, both by HRSA for their grants and by HCFA for their Medicare and Medicaid participation.

Health centers make their health services available at times and in locations that meet the needs of the people whom they serve, including evening and weekend hours as well as labor camp sites for farm workers and shelter-based sites for homeless persons.

Health centers follow their patients and provide continuity of care regardless of changes in their insurance coverage or health status. Last year, more than 1,000 health centers served over 11 million children and adults in 3,200 communities across the country. The health center patient profile nationally looks at about 4.5 million uninsured persons, which is one out of every 10 uninsured Americans; 4.5 million children including one of every five low-income uninsured children; 4 million Medicaid and CHIP recipients, or one out of every nine nationally; and more than 7 million people of color; 5.6 million rural residents, or one out of 12; and 600,000 or more agricultural farm workers and 500,000 homeless persons.

A typical health center operating budget reflects a four-pronged revenue stream. The Federal health center grant is a small part of overall health center revenue, providing for less than 28 percent of the operations. Medicaid and CHIP payments account for about 34 percent of their revenues. Medicare and private insurance payments, and support from State and local governments account for 31 percent, and every health center patient contributes to the cost of his or her care, and on average, 7 percent of income or revenue of the center. Therefore, any shift in any revenue streams, positive or negative, affects the totality of the whole.

Health centers are one of the best health care and taxpayer bargains anywhere. Health centers provide a comprehensive array of services to their clients for an annual payment of approximately $350 per year, which is less than $1 per day.

Several studies and reports show that health centers substantially improve the health of individuals in their communities and provide care in a highly cost-effective manner.

For State Medicaid programs, substantial savings are reported through lower hospital admission rates, shorter lengths of stay, and less inappropriate use of emergency rooms, lower infant mortality rates, higher childhood immunization rates, and better use of preventive health services than with other providers.

Health centers are doing their best to work within the changing health care system even as they are affected by trends that many other providers have been able to avoid, such as: 1) the rapidly escalating number of uninsured individuals, now more than 44 million; 2) the continuing loss of Medicaid coverage among some 2 million eligible low-income women and children because of decoupling of Medicaid coverage from welfare benefits, further compounded by the failure of most Sates to abide by current law requiring the outstationing of Medicaid eligibility and enrollment workers at health centers and other safety net providers; and 4) the decline in charity care by other nonsafety net providers.

Having said that, it should come as no surprise, then, that as a result of these pressures, many health centers are financially pressed and some are struggling to keep their doors open. Health centers request that this committee and Congress act to support our work in several specific ways.

We strongly recommend that the reauthorization of the Federal Health Center Grant Program under Section 330 of the Public Health Service Act proceed on schedule next year. There are steps that this committee and its members and the Congress can take this year to expand and improve access to quality health care for uninsured Americans. First, support an expansion of the health center program to double the number of uninsured and underserved people they serve over the next 5 years, beginning this year with a 15 percent increase or $150 million in the next fiscal year.

Second, expeditiously reauthorize and strengthen the National Health Service Corps and streamline the program to work more effectively with safety net providers including health centers who share the goal of improving health care access in underserved communities.

Third, fully support S. 1277, the bipartisan Safety Net Preservation Act, which would establish a permanent, stable, and fair Medicaid prospective payment system for health centers.

Fourth, reauthorize the Ryan White CARE Act this year and strengthen its impact by funding programs targeted on those populations most at risk for HIV.

Fifth, support a more active role for health centers in enrolling children and other eligible persons in Medicaid and CHIP, pressing for full compliance with the outstationing requirement in Medicaid law.

Regarding the new Community Access Program that has been proposed and funded for this year, we welcome any effort that holds the promise of improving access to needed care for the uninsured as long as the resources provided for the new program do not come at the expense of support for those programs already targeted to serve low-income, largely uninsured, programs like health centers, the National Health Service Corps, and the Ryan White CARE Act programs.

We believe that local efforts funded by the CAP program must clearly include local safety net providers as participants and core decisionmakers.

We encourage all health centers to get actively involved in putting together networks. We are cautiously optimistic and hopeful that this program will work so long as we all work together to avoid confusion and duplication of effort.

Thank you for this opportunity to present our views. We look forward to working with all the members of the committee to improve and expand access to vital health care services for many more of America's uninsured and underserved.

Thank you, Mr. Chairman.

Senator FRIST. Thank you, Mr. Simmons.

[The prepared statement of Mr. Simmons may be found in additional material.]

Senator FRIST. Dr. Bufwack?

Ms. BUFWACK. Senator Frist, thank you for the deep concern you have shown for the undersexed and the uninsured.

I am CEO of United Neighborhood Health Services, and my name is Mary Bufwack. With me today is the secretary of the United Neighborhood Board. She is also president of the Cayce Homes Residents' Association. There, in the early 1970's, the orga-

nizing effort of the Cayce mothers resulted in a clinic that became United Neighborhood. I would like you to meet Wanda Hugger.

Over that 25 years, United Neighborhood has grown to six centers serving over 10,000 a year with 31,000 visits. Fifty-two percent are uninsured; 42 percent are enrolled in TennCare; 3 percent receive Medicare, and a scant 3 percent receive private insurance.

Our patients are poor—86 percent—and they suffer the health disparities of the poor and racial and ethnic minorities. The ways we have responded to their health needs include: a perinatal program; services in a neighborhood with the highest rate of syphilis and new cases of HIV infection; an AmeriCorps Program with 35 members providing home visits to new mothers; a bilingual service for Nashville's 30,000 new Spanish speakers; a diabetes initiative; two school-based centers, one serving a middle school where, before the center began, a dead infant was found in a toilet and where 14 pregnancies per year was the norm, and one serving a preschool in a violent and drug-ridden community with a 60 percent failure rate in the first grade; and, opening on April 1st, a women's health and freestanding birth center.

The National Health Service Corps has been a critical partner. Over 20 providers have given more than 50 years of service. When I first joined United Neighborhood, all three staff physicians were Corps Scholars; today, one is a Scholar, one completed his service 2 years ago, another 15 years ago. I do not exaggerate when I say that without the Corps, we would not exist.

Recent health professional shortage area de-designations have put health center staff in jeopardy. Nashville's Matthew Walker Comprehensive Health Center, with 50 percent uninsured patients, lost its HPSA designation last year. Facility designation for centers would simply solve this problem.

Finally, while Medicaid is not the jurisdiction of this committee, it is a fact that half of our clients are uninsured and the other half are TennCare. Just as one hand helps us through the health center program, the other is tearing us apart.

Implemented in 1994, TennCare—Tennessee's Medicaid managed care experiment—added 500,000 uninsured, remarkably, to the 800,000 Medicaid recipients. The uninsured in Nashville were cut in half, from 80,000 to 40,000.

The untold part of this story is that simultaneously, services for the uninsured dried up. In Nashville, the Public Health Department eliminated primary care services and closed five neighborhood centers.

Today, immigration is pushing the uninsured well above that 40,000, and many who had coverage are losing it. The safety net was capable of serving 40,000. Today, it can serve a little over 10,000.

When United Neighborhood had reasonable cost-based reimbursement, our grant funds were freed up, and we could expand services to the uninsured. Under the TennCare Program, 17 Tennessee health centers, 63 sites, serving 55,000 uninsured and 90,000 TennCare, are now the guinea pigs for an experiment, and the question is: Can community health centers function and survive under a paying system that was set up to pay us significantly

less than cost. Yes, we have survived—living hand-to-mouth and from payroll, we are keeping our doors open.

Yes, we have survived—to maintain the level of medical services, we cut all allied health services.

Yes, we have survived—in 1999, United Neighborhood used $300,000 of Federal funds and contributions, 10 percent of our budget, 20 percent of our Federal grant, to subsidize TennCare.

Had TennCare paid its $300,000 debt to United Neighborhood, we would today be providing an additional 4,000 visits for 1,500 uninsured; for homeless people; for a pregnant woman legally resident in the U.S.; for a songwriter struggling to have his voice heard; for a 2-year-old child with hearing difficulty; for a young couple starting a restaurant; for a senior citizen who cannot purchase medications.

In summary, you can help us. First, substantially increase resources for health centers. Second, reauthorize and strengthen the Corps and automatically give facility designation to health centers. And third, please work with your colleagues to enact Senate bill 1277, the Safety Net Preservation Act. Health centers deserve a fair, stable Medicaid payment system.

Thank you.

Senator FRIST. Thank you, Dr. Bufwack.

[The prepared statement of Ms. Bufwack may be found in additional material.]

Senator FRIST. Dr. Taube?

Mr. TAUBE. Thank you for inviting me to testify today. As you know from Senator Kennedy's very gracious introduction, my name is Bob Taube, and I am with the Boston Health Care for the Homeless Program. I am also a member of the board of directors of the National Health Care for the Homeless Council, on whose behalf I am testifying today.

Before I begin, I want to extend our deep and heartfelt appreciation to you, Chairman Frist, and to you, Senator Kennedy, to Senator Jeffords, Senator Dodd, and to Senators Collins and Reed, who are not present at the moment, and other committee members for ensuring that last year's reauthorization legislation for SAMHSA included the renewal of two targeted homeless addition and mental health service programs. These programs are critical components in the Federal response to homelessness.

Recognizing that nearly three-quarters of those experiencing homelessness frequently lack insurance and access to services, Congress established a targeted health program specifically for homeless people in 1987. In 1966, this program was reauthorized in the Consolidated Health Centers Act. My project, the Boston Health Care for the Homeless Program, is one of 130 grantees in 48 States who served 430,000 homeless patients in 1998. In Boston, we served 7,000 of these patients—men, women, and children—providing a comprehensive array of primary care, oral health, mental health and substance abuse services, HIV services, and a unique service that is absolutely essential for homeless people which is a recuperative care program that people who are homeless and not sick enough to be in the hospital but too sick to be in a shelter or on the street can come and stay and receive medical care until they are well enough to resume their lives.

The Boston Health Care for the Homeless Program, like other HCH programs nationally, has developed an extensive service network operating out of three hospital-based clinics and over 50 community-based sites spanning homeless shelters, soup kitchens, and detox programs. We also provide services to unsheltered people on the streets and under bridges as well as at a local racetrack, where otherwise homeless and itinerant workers reside in barns during the racing season.

Nationally, the Health Care for the Homeless Program is highly successful. Sometimes its success is measured in terms of life and death. In the winter of 1998, Boston witnessed 16 deaths of homeless people on the streets. The community's concern grew with the mounting death toll, and acting in our bridging capacity between medicine and public health, our program undertook a case-by-case mortality review of the circumstances of each death. Finding patterns enabled us to identify those currently at greatest risk of dying on the streets and enabled us to propose and coordinate a response supported by hospitals, detox programs, shelter outreach teams, and our health care practitioners. This winter, with this response in place, four people have died on the streets, and while four homeless street deaths is still four too many, it is gratifying to see this dramatic decrease from a year ago.

Success in our work requires well-trained and committed health care providers, and the National Health Service Corps has helped us to do this. We fully support its reauthorization, and I would be pleased to talk in more detail if there is time later about some of the specifics of how it is has helped our program.

The fundamental challenge facing all health care for the homeless projects as well as health centers is one of insufficient resources in the face of growing need. One of the ironies of our current prosperity, as Chairman Frist mentioned, in terms of the growth of the uninsured population is that our prosperity currently seems to be breeding homelessness as well. As housing prices rise faster than the incomes of low-income workers, an increasing number of individuals and families, because of our prosperity, find themselves living with friends and relatives, in shelters, and in the streets.

In Massachusetts, the two fastest-growing homeless groups are young people between the ages of 18 and 24 and the elderly.

Many Health Care for the Homeless projects, like community health centers across the country, are struggling financially to meet this increasing need. The enrollment of Medicaid beneficiaries in managed care organizations has contributed to this struggle, resulting in increased reimbursements received from Medicaid. The planned phaseout of Medicaid cost-based reimbursement to health centers also threatens revenues during a period in which actual costs continue to rise.

The National Health Care for the Homeless Council recommends that Congress take the following actions to respond to the challenge facing Health Care for the Homeless Projects.

First, use the remaining year to conduct a deliberative reauthorization of the Consolidated Health Center Program to include the following—first, that the Health Care for the Homeless Program remain a distinct program within the Consolidated Health Center

account; ensure that appropriate allocation of funds among all health center programs within the Consolidated Health Center account occurs; and include an authorization amount that is at least 100 percent above the fiscal year 2000 appropriation level.

On the appropriations side, we ask for the requested $1.5 billion appropriation for the Consolidated Health Center account; $75 million for the PATH Program, and $100 million for the GBHI Program in fiscal year 2001.

If these requested funds were available, they would be put to good use in expanding access to dental services, mental health and substance abuse services, and recuperative care.

Thank you for this opportunity to testify.

Senator FRIST. Thank you, Dr. Taube.

[The prepared statement of Mr. Taube may be found in additional material.]

Senator FRIST. Mr. Gage?

Mr. GAGE. Thank you very much, Mr. Chairman.

I am very pleased to be here today and to be invited to testify, especially because, as you noted in your kind introduction, I began my career as a professional staff member of this committee, working for Senators Gaylord Nelson and Bill Hathaway. I spent many happy hours sitting on that bench behind you, although they may be happier in retrospect than they were at the time. [Laughter.]

NAPH is an organization that includes approximately 100 of the largest urban metropolitan area public hospitals in the country. I am very pleased to be here this morning even though we spend more of our time with the Senate Finance Committee on the Medicare and Medicaid programs because of an important and exciting new initiative that Dr. Fox mentioned this morning, which is the Community Access Program.

My prepared testimony this morning, which I will summarize, touches on four points. First, it describes the situation of America's urban public hospitals. Second, it indicates the near universal public support for protecting and strengthening all safety net providers, not just hospitals. Third, it discusses in more detail the new Community Access Program and urges your support for needed authorizing legislation. And finally, it also touches on several other initiatives pending before Congress to assist safety net providers and improve access for the uninsured.

With respect to NAPH and public hospitals, perhaps the most important fact to note is that over 80 percent of the services of these hospitals are provided to Medicaid or Medicare patients or to the uninsured. Twenty-eight percent of the services are provided to the uninsured, and those numbers are growing. On the outpatient side, we also provide a tremendous volume of uncompensated services. In 1977, just 77 of our hospitals provided 25 million outpatient visits, 42 percent of which were for uninsured patients.

Overall, our members shoulder a tremendous burden of uncompensated care, and like the number of uninsured, that burden has been rising. In 1997, 29 percent of the total costs of our member hospitals were uncompensated, up from 23 percent in 1993. And I will refer you to my testimony and to the charts for additional facts about public hospitals.

Now, perhaps because of this burden, public support for safety net providers is universal and overwhelming. Last May, perhaps in honor of the forthcoming election year, we decided to conduct our first poll of 1,000 Americans in urban and suburban households to assess their support for safety net providers. We found an overwhelming endorsement cutting across all ages, genders, income levels, races, and political affiliations. Ninety-six percent of respondents said that it is important that safety net hospitals and clinics exist in their communities to care for the uninsured. Eighty-five percent said it was very important, and 72 percent said that more money should be spent on these providers, and a majority indicated they were personally willing to contribute more money out of their own pockets.

Perhaps the reason for that is that over half of the people that we polled said that they are currently uninsured or have been uninsured in the recent past, and one-third of the currently insured individuals we polled thought that they or a family member was going to become uninsured in the next 5 years. So this is a tremendous concern for Americans.

Let me turn to the Community Access Program, because we believe that this program will help integrate care for the uninsured. We have long believed that the solution to the problem of the uninsured lies in universal coverage, and this is a goal that we continue to commit ourselves to. We do not see it becoming reality any time in the near future. And as a complement to the incremental approaches that are being adopted or proposed today, we also believe that we need to address the issue of access to care for low-income patients. Moreover, as we have learned in many communities, simply giving someone an insurance card does not guarantee access to geographically and culturally appropriate providers, nor do some programs like TennCare, which was discussed earlier, pay providers adequate for the care that the beneficiaries are entitled to.

The Federal Government currently invests billions of dollars in support of safety net institutions through a variety of programs, many of them under the jurisdiction of this committee. Most of these programs are targeted on a particular type of provider. There is no Federal funding source that cuts across these program lines and encourages the different types of safety net providers to work together. As a result, from the perspective of the uninsured individual, the care that he or she receives is often fragmented and inefficient.

The Community Access Program in its own perhaps modest way is intended to provide competitive grants to safety net providers within communities around the country to encourage them to collaborate in providing care to the uninsured. The idea is not to impose a Federal, one-size-fits-all solution on the entire country, but rather to let each community assess its own needs and develop its own solutions. The primary Federal requirements are that grants be to consortia of providers, that the projects enhance care for the uninsured, and that the recipients demonstrate an historical commitment to serving the uninsured.

Finally, let me conclude by briefly summarizing several other proposals to strengthen the safety net and improve access for the uninsured. These include expanding the Children's Health Insur-

ance Program to cover parents, pregnant women, and other populations; expanding outreach and enrollment initiatives to ensure that those who are eligible for existing programs are actually covered; enacting a bipartisan proposal that has been introduced in the House to alleviate the impact of a provision of the Balanced Budget Act reducing State allocations for Medicaid disproportionate share hospital payments; and finally, substantially increasing payments under Section 330 for community health centers so that services can be doubled over the next 5 years.

Also, it goes without saying that we certainly support the extension, the reauthorization, and the expansion of the National Health Service Corps which is also before you today. Many of our members serve medically underserved areas and health professional shortage areas, and either employ or work closely with Corps members and graduates.

Thank you.

[The prepared statement of Mr. Gage may be found in additional material.]

Senator JEFFORDS [presiding]. Thank you, Mr. Gage, and thank you all for very excellent statements.

We are in the middle of a vote right now, but I am going to question for a while, and Senator Frist has already gone to vote and will be back shortly.

Dr. Dean, from your testimony, it is clear that the National Health Service Corps was vital to the recruitment and retention of clinicians who practice in your clinic. We hear a lot about the need to ensure that providers are not placed in solitary practice environments. How important was it for you that you were one of five clinicians hired to start your rural health initiative project?

Dr. DEAN. I think it was important in terms not only of the additional professionals who were in our local setting, but the Corps really provided some backup assistance through the regional office and so forth that gave a sense of security that I think is a major issue in getting especially young professionals into isolated communities, because it is a pretty intimidating undertaking to go to a small communities where there is limited backup. I think that as these programs have developed, there is much more of an emphasis on building networks and infrastructure that will allow young professionals to try out, if you will, this type of practice in a way that I think is less threatening than if they had to do it on their own. So it was important, and I think it continues to be a major positive aspect of the Corps.

Senator JEFFORDS. Suppose you had been alone; do you think you would still be there?

Dr. DEAN. No. I can answer that very clearly—even though it is my home town, and I had all kinds of personal support, I could not have done it by myself, just plain and flat out.

Senator JEFFORDS. I have a question now for the entire panel. Like the rest of the country, one of the greatest health care challenges that we face in Vermont is the rising price of pharmaceutical drugs. We are working hard to find ways to make medications more affordable to those who need them. How important is the Federal drug pricing arrangement that community health centers use to your ability to deliver care.

Let me start with Mr. Gage and work down the panel.

Mr. GAGE. Well, that is an extremely important program. We have actually developed a coalition of both public hospitals and other providers to support that program and prevent it from being eroded. The 340(b) program, as it is called for at least our members, enables them to save sometimes millions of dollars on drugs that they purchase for the uninsured—and this is millions of dollars for each provider, each hospital, and I am sure the savings are equivalent among other providers.

Senator JEFFORDS. Mr. Taube?

Mr. TAUBE. We believe that it has great promise for us, although it has not yet been realized in the case of our program. What we are working on now, and where we think it will be of help, is in our recuperative care facility, where we provide a tremendous amount of medication for people who are quite ill and often uninsured. So we are in the process of becoming a provider through that program, and I can probably better answer this question some months from now.

Senator JEFFORDS. Dr. Bufwack?

Ms. BUFWACK. It is a tremendous asset. Our growing pharmaceutical costs before we had the opportunity to do that were just enormous and taking up enormous amounts of our Federal grant to be able to support that, because we had to have the medication to go along with the treatment. Now, with that, is a very containable cost. It is a marvelous savings that we can put into other uninsured care. It has just been a tremendous boon to us.

Senator JEFFORDS. Mr. Simmons?

Mr. SIMMONS. Our urban health center, Senator Jeffords, is a real benefit with in-house pharmacies. Rural programs may not have in-house pharmacies. This is yet to be realized. It is very difficult to get retail pharmacists to isolate their inventory and make drug pricing available through prescription-dispensing for us. I think it has a benefit for rural programs that is yet to be seen, but with networks forming as they are now in the health center system, I believe that in-house pharmacies and the drug pricing benefit will be realized.

Senator JEFFORDS. Dr. Dean?

Dr. DEAN. Our experience is the same as Mr. Simmons'. We have not been able to take part in that yet, and the pharmaceutical costs are a huge threat and a real burden to maintaining up-to-date care for our rural population.

Senator JEFFORDS. Dr. Frist will be back shortly. I have about 4 minutes left to vote and a sprained ankle, so I am going to have to take off now.

Thank you very much. [Pause.]

Senator FRIST. Thank you all for your patience.

Dr. Bufwack, TennCare, Medicaid, and we heard a little bit earlier about 1115 waivers more generically and the challenge—when you are sitting at a group of centers such as yours, and you are talking to Medicare/Federal Government, you are talking to Medicaid/State predominantly, you are talking to us and the funding that we are talking about specifically today, and recognizing that for better or worse, that is the system that we have today, how best can coordination be elevated from what you do when you are sit-

ting around that table, struggling with each of these to a system that makes more sense in terms of—I will start with budgeting, because that is dollars and cents, and you can measure the pie and the changing aspects of the pie. Do you have any thoughts—and then I will ask the other panelists—about how that coordination in this changing environment can take place beyond just the table and the rooms that you sit in where needs can be clearly identified which you can do, but matched with the resources in a way that captures everybody's good intentions for the most part, but clearly are at a loss? All of you have the frustrations of being at that table, and then you come to bodies like this which are well-intended but do not directly affect the State, have an indirect effect through Medicare and then our own direct funding.

I will start with you.

Ms. BUFWACK. At the Federal level, there does appear to be a lot of disconnect, and that really does have to be coordinated. At local levels, we are coordinating a lot—you are kind of mandated to coordinate. At the Federal level with these programs, it does seem that these departments and bureaus talking to each other and getting on the same page about this support is absolutely critical.

HCFA does play a very, very central role since that was where the waiver approval came through. Clearly, the Federal Government has a very significant role in monitoring how these State programs happen. With all the different variety of State programs happening, there should be some underlying principles, particularly in regard to these safety net providers.

When Tennessee went into this, I think we believed that the experiment—although we all knew it would never be 100 percent—was going to have a significant impact on the number of uninsured, so we would have a lot fewer uninsured, but it was also a system, as I said, that was initially based on an understanding that primary care providers—well, let me say this. They passed on the responsibilities to the managed care organizations, who then set up their payment structure knowing that they were not going to pay primary care providers any reasonable based cost. If the mandate had been clear from the top that a program that will not pay that categorical type of provider some reasonable based cost, with a plan that showed how that formula would happen, we would have been more compelled at the local level to have developed a satisfactory formula for all of us that we could then present to the Feds together and in fact been very supportive of the TennCare Program, which has shown great service to the uninsured.

That is not to detract from that program, but there was no coordination with the community health centers at that point because nobody told them they really had to coordinate in any meaningful way. They sent a plan up, and it was approved, but what they did was pass on to the managed care organizations the responsibility to do this cost-related reimbursement. But there was no check on whether there was any cost-related reimbursement happening, and it was not. It was take this contract or do not take this contract, and that is it.

So we were not a voice within Tennessee, and if the Federal Government said we had to be a voice, I think we would have had a more satisfactory plan to put in place a better program.

Senator FRIST. And do you see that as being a lesson learned that can be applied both in Tennessee and in other States?

Ms. BUFWACK. Absolutely. I hope that by sharing our experience, we will both give people heart that there can be a future, but we also sort of say watch out, because this is a thing that is going to really hurt things across the country if this is allowed to proceed this way.

Senator FRIST. Are there other thoughts from other panel members on this issue?

Mr. Gage?

Mr. GAGE. We have a number of members in Tennessee as well at the major public and teaching hospitals in the State, and I do not think you can assume that TennCare is the system that we are going to have for too much longer in Tennessee. If Blue Cross does not come to terms with the State and drops out on July 1st, I think that that program will basically implode. And I hate to say that more money is the answer. It is not the only answer. But adequate payments at every stage of the process, including plan premiums and provider payments, is very important, and also bearing in mind that some of the things that were done away with, like FQHC cost-based financing of health centers and others, really pulled the plug on institutions that still had a tremendous burden to carry because of the remaining uninsured and the underserved to the people who were enrolled in TennCare. If you couple that with the fact that some plans did not pay providers at all, so that regardless of the contracts they entered into, you had no effective monitoring of this at the State level, there were a lot of things wrong with TennCare.

I think if you set aside the cost issue, you also have the fact that it was really not managed care at all; it was managed cost, and there was never any effective case management of the positive aspects of managed care that can really help the uninsured gain access to services.

Senator FRIST. Thank you.

I have further questions on other 1115 States, but let me come back to those, because we have touched on so many issues, and our time is limited, and I want to move on to some other issues.

Dr. Dean, you talked about retention of providers in NHSC, and although this is clearly not the only measure of success of the program, I think it is an important one and one that we as a subcommittee look at very carefully.

Could you elaborate a bit on your recommendations to improve retention through community and site assessment and development and other kinds of tools that might improve retention in the program?

Dr. DEAN. Well, it is hard to know. Many of the issues that lead to either people staying or not staying are local issues. I think we certainly need more attention to site development and making sure that appropriate structures are in place to allow professionals to feel that they are contributing and practicing at a level that is consistent with their view of what quality is. I think that that is certainly possible in many areas, although it is sometimes difficult because these settings are very different from the areas that they are trained in, and oftentimes, the facilities and the access to the types

of specialty backup and so forth will be very different from what they are used to.

So I think there are a lot of challenges. I think we want to emphasize retention, and clearly, we want to try to build stable services at the same time. Even if you look at the private sector, there is a lot of turnover there, and I think we want to recognize that there probably will continue to be some turnover in these settings as well, because some of them are very difficult places to work. But site development is very important.

Senator FRIST. Are there other comments that people would like to make on the issue of retention?

Dr. Bufwack?

Ms. BUFWACK. The Bureau has done a great deal in helping us develop clinicians networks and aligning with training programs and teaching programs that really give physicians a multiplicity of experiences within community health centers that are very professionally fulfilling. I think that that has been very important.

Senator FRIST. Mr. Simmons?

Mr. SIMMONS. One of the other items that is of concern to us is that retention and filling the neediest places should not be looked at in terms of success of the Corps, because sometimes, to the person into the neediest places, a Scholar may have to be placed there who may not be retained of a period, and then retention should be looked at in terms of are we still serving the underserved.

The other item of concern is the fact of payment and decent salaries. Often, you are competing with people who have many more revenue sources to pay competitive salaries, and often, health centers just do not have the revenues to provide, and that is what that additional increase would do for community health centers, especially in hard-to-fill areas, to be able to provide a decent salary which is competitive with the prevailing marketplace.

Senator FRIST. Thank you.

Dr. Taube?

Mr. TAUBE. We have had mixed experience with retention through Corps Scholar placements. We have had several who have stayed who I believe will make a career out of it. But in truth, I think working in the kind of setting that we are has got to on some level be a calling, and it is not everyone's calling, although many of the people who have not stayed have gone on to work at other places in the area that care for low-income people; so I would not define that as failure.

But one of the most successful retention uses of Corps resources for us has, interestingly, been with nurse practitioners whom we hired without loan repayment as an initial part of the hiring package, who had been with us for a year or 2 years and who would have left because they simply could not afford to continue to work while they had such an outstanding debt burden. Now, these are people who have already chosen this as a place to work; it is a potential calling. They have worked there well for a year or two, and this enables them to stay.

So we have been really quite pleased with the use of loan repayment in those kinds of circumstances.

Senator FRIST. Thank you.

Mr. Simmons, Senator Kennedy mentioned and I want to ask on his behalf a concern to many of us, and that is issues surrounding outreach and enrollment for CHIP and Medicaid. Streamlining eligibility processes and outstationing workers in health centers and other community-based organizations are felt to be keys to success. How can we be sure that States are fulfilling their roles in this regard?

Mr. SIMMONS. I think we need better coordination between the funding stream that goes to States for their Medicaid programs and strict enforcement of the OBRA 1989-1990 regulation that requires them to do that. In our State alone, this has been one of the things that our Medicaid director has opposed over time, and because of State budgetary constraints, those employees are usually State employees, and often, State politicians tend to stay away from increasing the size of State Government. But I think better oversight and a better provision would be to have it as a mandate of States to do it through community health centers, and they would become health center employees with access to that system. That, as part of the tightening up of review at the Bureau and HRSA level, would assure that outstation eligibility and enrollment is going to enhance CHIP and outreach for underserved populations.

Senator FRIST. Mr. Simmons, you mentioned the safe harbor arrangements between health centers and other provides of health care as we look at the accessibility of health care services for health center patients being a common goal that we all share. Could you just elaborate a little bit on the safe harbor arrangements between the health centers and other providers of health care under the Public Health Service Act?

Mr. SIMMONS. Yes. We would love to see something in regard to safe harbor that reduces the expense of the Federal grant and provides access to care to more uninsured patients. Right now, an example would be a hospital that proposes to do lab tests for our patient population but would then serve our indigent patient population or those who have no insurance at half the cost or no cost—that would probably appear now to be fraud and abuse. We would love to see that be an allowable safe harbor provision that health centers can enter into arrangements with partners in their service areas to accomplish that.

The other is in the area of recruitment and retention. A hospital may offer to help recruit a physician for a particular health center or may propose to give them some in-kind services or may even provide a bonus to that health center for recruitment of that provider to the area, understanding that that provider will be required to have admitting and staff privileges at the local hospital. That would then constitute fraud and abuse. We would love to see that as part of the safe harbor provisions for community health centers, because that certainly benefits both and certainly helps to provide services to the underserved population.

Senator FRIST. Thank you.

Mr. Gage, in regard to the public hospital—and I know we have commented on this already—on both the overlap and the crossing over with the various programs we have talked about today, the Community Access Program would help communities integrate services to better meet whatever their specific needs are. Could you

elaborate a little bit on how the CAP program can better coordinate care delivered by public hospitals and other safety net providers?

Mr. GAGE. Certainly. Maybe the best way to do that is to point to a couple of specific examples, because the precursors to this program are a couple of programs developed by private foundations—the Kellogg Foundation and the Robert Wood Johnson Foundation. For example—the example I used in my testimony—the Denver Health System has a $2.5 million-per-year grant from the Kellogg Foundation to develop a network of safety net providers to approach the uninsured that involves school health programs, the public health department, the neighborhood health centers as well as the public hospital. Many aspects of the system right now are not functioning very well. For instance, the example of the safe harbor—right now, if a health center that is not actually owned by a hospital has to admit a patient, there are often barriers to that which involve information systems, which involve the fact that the hospital and health center physicians simply do not talk the same language, and breaking down those barriers can be extremely important to providing a continuum of care to even an uninsured patient.

It can also work the other way, where you can provide better care and more primary care and reduce unnecessary emergency room usage by coordination between the providers on behalf of the patient.

There can be patterns of care developed for patients with specific conditions like asthma or diabetes who require primary care, require outpatient services and occasionally require hospital services, but who very often in a fragmented system will simply go to the nearest provider if they do not have a primary care home. The goal is to be able to allow hospitals and primary care centers and other providers to coordinate the care of those individuals.

So there are many examples around the country right now that are already underway that HRSA hopes to build on in this first phase of the new program and expand and replicate across the country.

Senator FRIST. Thank you. Obviously, for all the issues that we are talking about today, we want to see what is really working, and that is the advantage of having people like all of you take time to come and testify here to help us learn what is working so that we can share that across the country.

Dr. Bufwack, you mentioned the changing of the health professional shortage area designations jeopardizing a health center's ability to quality for placement of providers. In addition, you recommend automatic facility designation as a solution to this problem. Could you explain a little more fully how the HPSA designation impacts a health center's funding, why changes are detrimental to the health centers, and how an automatic facility designation would correct this problem?

Ms. BUFWACK. In terms of particularly the Corps placement, to not be in a health professional shortage area of course eliminates you from consideration in that. If you are, like Matthew Walker, in close proximity to other health providers and other health facilities, when you use primarily those ratios of providers to residents

in those areas, you come out with a ratio that makes that now eliminated as a health professional shortage area.

In Nashville, we have done a great deal to cut those down by Census tracts and really trying to define the areas very closely, but when you are in that kind of geographical proximity, it really does not make a difference; it is not going to be a health professional shortage area. Therefore, you now no longer qualify.

I think another place where it is very important is when you are thinking about developing a new service. For instance, one concern we had was developing a new service for Spanish-speaking populations who actually, even though they are underserved, many are uninsured and need the service, they might not be residing in health professional shortage areas again because of the ratios.

So when you are looking at a new service and getting that service approved in terms of its location and then recruitment of physicians and providers to be in that, if your population is scattered or if your population now, even with moving people out of public housing, is being dispersed, the poor are dispersed in such a way that it becomes very difficult for you to argue that this is enough of an underserved area that you should be able to locate in that area.

So I think it prevents our being where we need to be sometimes and then also interferes with our ability to recruit providers.

Senator FRIST. Unfortunately, there is another vote, so we will have to close things down very shortly, and I appreciate everybody's patience.

Are there other comments from the panelists on the automatic designation?

Dr. Taube?

Mr. TAUBE. I will keep my comments brief. We have been a placement site for 4 years, and I have had the experience of working through the process of getting us designated, and it was a process that involved the best of intentions of everyone involved. I really developed an affection for the people I was talking with over an 8-month period, trying to get through what seemed very simple. We needed a psychiatrist. People who are homeless have a very high incidence of psychiatric need. And it did not matter that there were lots of psychiatrist in the community—they were not available to go under bridges. So it seemed like a pretty straightforward thing. There are categories for designating a population, so that homeless people should be designated.

It took us 8 months, and eventually, someone on the other end of the phone figured out that they could get us through this if they designated us as a facility. Up until that time, it was going absolutely nowhere. We were having to answer questions like: So, where is the nearest place someone can go?

Well, they cannot go anywhere.

Well, where is the nearest place?

Worcester, maybe.

Is there anybody in Worcester to see them? I do not think so. Is anybody from Worcester going to go under a bridge to see them? Probably not.

The process is an incredibly arcane one, and it seems like if you want to support the safety net system, you already have designated federally-qualified health centers, and you have the National

Health Service Corps Program, that linking the two and saying that anyone in this program is automatically a designated facility in the other would just save an awful lot of time.

Senator FRIST. Yes, Mr. Simmons?

Mr. SIMMONS. Dr. Frist, we also support the facility designation provisions of the Corps. Often, community health centers become victims of their own success, particularly in rural areas. They work to reduce infant mortality, and they bring doctors to town, and when you look at the provider-to-user ratios, then they become ineligible for designation as health professional shortage areas for the reasons Mary has suggested. Facility designation would certainly alleviate that in many rural communities where they may be competing for standard lives as a health professional shortage area.

Senator FRIST. Thank you. I want to thank all of you. This is a hugely important issue and, as I think you can tell from the questions asked, one that is very important to us to see how we can improve and make the outstanding jobs that you are doing a little easier as we reach out.

Dr. Bufwack?

Ms. BUFWACK. If I could elaborate on the first question you asked me just one more minute——

Senator FRIST. I literally have to be in the United States Capitol in a couple of minutes, but we will keep the record open—I do not mean to cut anybody off—we will keep the record open for your comments and include them as part of the record.

I do want to thank all the witnesses. This has helped us to much better understand where we are today and where we need to go. The hearing has helped to highlight several issues that I needed highlighting, which all of you have contributed to today. It is an ongoing dialogue. We will continue to reach out.

If there are further comments, please do submit them for the record and we will share the record quite broadly.

With that, we stand adjourned. Thank you very much.

[Additional material follows.]

Additional Material

Prepared Statement of Claude Earl Fox, M.D.

Mr. Chairman, and Members of the Subcommittee: I am Dr. Claude Earl Fox, Administrator of the Health Resources and Services Administration (HRSA), and I am very pleased to appear before you today to discuss an important issue for this country: access to critical primary health care services for uninsured and medically underserved individuals. HRSA's mission is to improve the health of those Americans who are too poor, too sick, or too isolated to access essential health care services, and there are multiple access barriers including cost, capacity and distribution, or fragmentation. We are the Access Agency. We decrease these barriers through building primary care delivery systems in places where they are sorely lacking—rural communities, public housing complexes, and urban areas where private health care systems are scarce or nonexistent. Through expanding primary care capacity, we are also decreasing disparities in health status experienced by the poor and the underinsured. We are honored to be entrusted with such an important mission and justifiably proud of what we have achieved. But we are also concerned that despite our best efforts, economic, social, and environmental events have created a greater need for the kinds of programs that HRSA supports. Today there are more than 44 million Americans with no health insurance (and that number is growing), and 43 million Americans lack access to a primary care provider. In his Fiscal Year 2001 Budget, the President unveiled a 10-year, $110 billion initiative designed to dramatically improve the affordability of and access to health insurance. The proposal would expand coverage to at least five million uninsured Americans and expand access to millions more. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative would (1) provide a new affordable health insurance option for families; (2) accelerate the enrollment of uninsured children eligible for Medicaid and SCHIP; (3) expand health insurance options for Americans facing unique barriers to coverage; and (4) strengthen programs that provide health care directly to the uninsured. Today I want to discuss three unique and essential safety net programs that serve to reduce the barriers and increase access for this Nation's uninsured and underserved population by strengthening and expanding that safety net: the new Community Access Program (CAP), National Health Service Corps, and the Consolidated Health Centers.

COMMUNITY ACCESS PROGRAM (HEALTH CARE ACCESS FOR UNINSURED WORKERS)

I would like to start with the exciting new Community Access Program. It will help us to further assist communities in developing innovative ways to develop integrated delivery networks for the uninsured with a focus on eliminating fragmentation, improving efficiencies in the health care delivery system, and leveraging private sector involvement, where appropriate. This initiative is truly about catalyzing collaboration. At the community level, CAP seeks to build partnerships among health care providers to better integrate services for the uninsured. The grant program would assist safety net providers in developing community-wide infrastructure to assure adequate access to a broad range of health services, thereby allowing these systems to provide more and better care. At the national level, the Department is collaborating with the Robert Wood Johnson Foundation and the Kellogg Foundation to ensure that CAP builds their existing efforts to strengthen the safety net.

In the fiscal year 2000 appropriation for the Department, Congress made available $25 million for a Community Access Program to assist communities and their safety net providers in developing integrated health care delivery systems that serve the uninsured and underinsured and building the infrastructure necessary to manage efficient and effective health systems. Potential grantees are public or private entities that demonstrate a commitment to, and have experience, with provision of care to uninsured people. Applicants should represent community-wide coalitions that are building networks of providers that will provide care to the community's uninsured and underinsured populations regardless of ability to pay. These networks are comprehensive and include prevention, and primary and secondary care. We encourage incorporation of mental health and substance abuse services. The funds can be used to streamline eligibility determination, enrollment, case management and referral, tracking systems, and filling unique gaps in service needs all for the purposes of improved health outcomes for uninsured and underserved people.

The response to the grant announcement in the Federal Register on February 4, 2000 has been overwhelming. We have requests for almost 1,900 application kits. Approximately 1,000 persons attended pre-application technical assistance workshops recently completed in 6 cities across the country. We witnessed partnerships

materializing before our eyes at the technical assistance workshops as providers realized how they could join forces to work together more effectively. The level of interest and commitment evidenced to date suggests that communities across the country are eager to work together to develop better ways to improve access to care for the uninsured and are greatly in need of Federal assistance to kick start their efforts. This year we anticipate awarding approximately 20 grants of up to $1 million each. These grants will serve to demonstrate innovative or creative methods to integrate health care systems.

The Administration is requesting $125 million in funding for the Community Access Program in fiscal year 2001. Fiscal year 2000 funded communities may be eligible for available fiscal year 2001 funding to support further infrastructure development and filling service gaps. In addition, fiscal year 2001 funding would support integrated health service networks.

The Administration is aggressively pursuing legislative authority to ensure that the Community Access Program becomes a core element of the health care safety net. Our legislative proposal gives communities flexibility in developing integrated care systems that build off traditional safety net providers and encourage innovation without supplanting funding for existing federal programs that provide services to low-income populations. We urge passage of our forthcoming legislative proposal.

NATIONAL HEALTH SERVICE CORPS

HRSA, through the National Health Service Corps, has collaborated with communities for 25 years and has served as a critical piece of the health care safety net by assisting frontier, rural, and inner cities to recruit clinicians to meet their needs. Despite the fact that there is an oversupply of physicians in this country, there is also severe maldistribution. Therefore, there is still a need for the National Health Service Corps to address the problems of capacity. According to the Council on Graduate Medical Education (COGME), physicians are not being trained in the right specialties; physicians are not working in the right places; and physicians are not serving the populations with the greatest disparities in access and health status. Further, the racial and ethnic diversity of the Nation's health care workforce does not reflect that of our population that is in most need of its services. HRSA remains committed to addressing health disparities and the lack of access. Maldistribution is a barrier to both access to care and to the elimination of health disparities that the National Health Service Corps is uniquely positioned to address.

Today, National Health Service Corps clinicians serve in every State, the District of Columbia, Puerto Rico, and the Pacific Basin. These clinicians include 533 scholars, 1,306 loan repayors, and, through the National Health Service Corps' partnership with 33 States, 508 State loan repayors. Historically, 60 percent of the National Health Service Corps clinicians serve in rural areas, reflecting the National Health Service Corps' ability to respond to the critical access needs of these communities. In this fiscal year, the National Health Service Corps anticipates that approximately 400 scholars will be available for service, and nearly 800 additional scholars will be in the path for future service. The composition of the National Health Service Corps' Field Strength is an expression of its interdisciplinary approach to health care: 13.5 percent physician assistants, 3 percent certified nurse midwives, approximately 12 percent nurse practitioners, over 12 percent dentists and dental hygienists, 8 percent mental and behavioral health clinicians, and approximately 50 percent physicians.

We believe the National Health Service Corps is working, and I would like to take a moment to review the successes of the National Health Service Corps: Over 22,000 clinicians have provided needed services since 1972—spending all or part of their careers serving where others choose not to go; Approximately 97 percent of clinicians fulfill their commitments; Approximately 60 percent of the National Health Service Corps alumni continue to serve the underserved four years after completion of their service obligation; National Health Service Corps clinicians are selected to best match the characteristics of the communities they serve; National Health Service Corps clinicians include significantly higher percentages of underrepresented minorities than the Nation's workforce, and over 30 percent of its awards went to minorities; The National Health Service Corps targets areas with high disparities in access and health status; National Health Service Corps interdisciplinary teams assist in meeting the primary care needs of the Nation; and National Health Service Corps clinicians must provide services to all, regardless of an individual's ability to pay.

We believe the need for a National Health Service Corps is clear, and we can go farther: Maldistribution continues; Community demand is three times the supply; 800 physicians leave health professional shortage areas annually; Currently, the

National Health Service Corps' 2,500 clinicians addresses 12.5 percent of the overall need (16.4 percent of primary care need, 6 percent of oral health need, and percent of mental health need); 20,402 clinicians could be used in communities (12,303 primary care, 5,179 oral, and 2,920 in mental and behavioral health).

For the above reasons, we strongly urge that you reauthorize the National Health Service Corps for a five-year period before this Congress adjourns. Flexibility is key to our ability to react to a rapidly changing health care marketplace and environment. For example, a demonstration authority would allow the National Health Service Corps clinicians to serve the community on a less-than-full-time basis. Also, the flexibility to award scholarships consistent with community demand for clinicians is a change that could be considered. The current legislative requirement which sets aside scholarship funding for specific disciplines regardless of community need for their services. Finally, we are very aware that to be truly effective in addressing the needs of the community, a primary care health delivery system must be integrated with a dependable referral network. Over its history, the National Health Service Corps has effectively contributed to the strengthening and expansion of the health care safety net. We believe the National Health Service Corps stands ready to increase access to primary care services by exercising flexibility in being community responsive: by leveraging resources with communities as they prepare to attract and retain clinicians. The Program, and its clinicians, will have a significant impact on the Nation's health both now and in the future.

CONSOLIDATED HEALTH CENTERS

Another of HRSA's three safety net programs is the Health Centers. Health Centers comprise a consolidation of the Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, and Health Care for Residents of Public Housing. Collectively, these programs provide case-managed, family-oriented preventive and primary health care services to over 9 million people, including 3.5 million children, who live in medically underserved rural and urban communities. The Health Center program has an extraordinarily successful track record of delivering cost-effective, high quality primary health care to underserved, low income, and minority populations for more than 30 years. The Health Centers comprise 700 community-based organizations with 3,100 sites employing 50,000 full-time employees, representing over 75,000 employed individuals (including 8,000 clinicians), and involving 10,000 community members participating on Health Center boards. The Health Center patient population consists of approximately: 86 percent below 200 percent of poverty; 40 percent uninsured (Health Center uninsured patients have increased at twice the national rate since 1990); 34 percent Medicaid recipients; 65 percent minorities; 40 percent children; and 30 percent women of child-bearing age.

The Health Centers are invaluable safety net providers: essential, effective, and efficient. They are located in low income and minority neighborhoods, underserved rural communities, and in communities with a disproportionate number of at-risk people. The homeless community is particularly in need of health services. Health Care for the Homeless is part of the Consolidated Health Centers program and serves nearly 438,000 homeless patients (75 percent of whom are uninsured) through culturally competent clinicians—homeless individuals and families who might otherwise have not received care from a safety net provider.

Health Centers have demonstrated their effectiveness by: improved health outcomes; increased preventive services improved management of chronic disease reduced avoidable hospitalizations; and high patient satisfaction.

Health Center low birth weights approximate the national average for all infants and are lower than the national average for African American infants. Women served at Health Centers received more up-to-date mammograms than women in the general population (62.2 percent to 44.5 percent). African American and Hispanic with hypertension using Health Centers are three times as likely to report blood pressure under control as a National Health Interview Survey comparison group. Medicaid Health Center patients have significantly lower odds of being hospitalized for an ambulatory care sensitive condition than Medicaid non-Health Center patients (MDS Associates, 1996). Health Center users report high satisfaction levels (94 percent overall satisfaction).

Not only are Health Centers seen by HMOs as effective partners, but studies comparing Health Center patients and non-patients show: lower cost per ambulatory visit; lower rate of hospital inpatient days and lower inpatient care costs; and lower total costs.

Health Centers are the building blocks for the CAP initiative: support for 44 practice management networks and 13 managed care networks consisting of Health Centers partnering with hospitals, health departments, sub-specialists, and other safety

net providers; 21 Health Center-controlled managed care plans involving 125 Health Centers in 12 States; Health Centers were the impetus for the CAP Access for Uninsured Workers initiative with models in Brooklyn, New York and Marshfield, Wisconsin.

Health Centers also utilize resources totaling approximately $3 billion in cash revenues (Medicaid, Federal, State and local support; other third party reimbursements; and patient fees). Taken together, these resources positively impact economies (local jobs, goods, and services). Health Centers receive $3 for every $1 in Federal grant support: $2 in insurance and patient payments and $1 in State, local, and private grant and contract support. Health Centers serve as catalysts for economic development: generate jobs; provide job training opportunities; utilize local suppliers; attract complementary businesses (i.e. pharmacies and labs) and; provide an overall economic multiplier effect on the community's economy.

In collaboration with other safety net providers, HRSA's indispensable Health Centers are truly the access workhorses of increased access for the uninsured, underinsured, and underserved.

CONCLUSION

In conclusion, we at HRSA are extremely proud of our safety net providers, and in collaboration with our partners who operate the nations's public hospitals, we look forward to working with the Subcommittee in strengthening the safety net. However, our truest source of pride is with our clinicians in the field—at our Health Centers and National Health Service Corps sites serving 10.35 million underserved people at 3,800 sites. Their dedication, humility, and steadfast purpose, in serving one in every 6 low income children, one in every 7 low income uninsured individuals, one in every 10 Medicaid recipients, one in every 5 homeless persons, and one in every 5 migrant farmworkers, as well as the courage and humility of their patients, is a lesson to us all, and a clarion call to us to remedy this uninsured crisis with all deliberate speed.

Chairman Frist, Senator Kennedy, and members of the Subcommittee: I would be happy to address any questions you may have.

PREPARED STATEMENT OF JANET HEINRICH

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you discuss federal safety-net programs intended to improve access to medically underserved populations. As you know, many Americans face barriers to obtaining primary health care. These Americans may live in isolated rural areas or inner-city neighborhoods and lack access to health services or a sufficient number of health care providers. In addition, an increasing number of people lack health insurance. Research shows that people in these situations use less care, often forego seeking care when ill, or travel long distances to get care.

My statement today will focus on two safety-net programs administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA): the Community and Migrant Health Center program and the National Health Service Corps (Corps). Community and Migrant Health Centers (health centers) were authorized about 35 years ago to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. In some communities, these centers may be the only primary care provider available to vulnerable populations, such as minorities and uninsured families. Health centers rely on public and private funding sources, including federal, state, and local governments; foundation grants; and payments for services from Medicaid, Medicare, private insurance, and patients. Fiscal year 2000 appropriations for the Consolidated Health Centers program totaled over $1 billion. The National Health Service Corps provides some of the health professionals who work in the centers and other sites in communities where there is a shortage of providers. The Corps offers scholarships and educational loan repayments for health care professionals who, in turn, agree to serve for specific periods in communities that have a shortage of health professionals. Since its establishment in 1970, the Corps has placed thousands of health care providers, including physicians, nurses, and dentists, in such communities. The information presented today is based on our report on health centers, being issued today at the request of you and Senator Jeffords, and on several reports we have issued since 1995 related to Corps operations and other efforts to improve access to care. We conducted follow-up work to update the findings and recommendations contained in the earlier reports.

In brief, we found that both the health centers and the Corps are important safety-net providers to our nation's vulnerable populations, but we believe certain improvements would enhance the effectiveness of these programs. Most health centers

continue to be able to serve vulnerable populations, even though a number of significant changes have occurred in the health care environment. HRSA has helped centers respond to developments such as the growing number of uninsured and Medicaid's increased use of managed care by encouraging centers to form networks and participate in managed care. HRSA could increase its effectiveness, however, by establishing a systematic Abest practices program to allow centers to learn from one another and by improving the completeness and accuracy of its data—especially financial—that are used to monitor centers. The Health Care Financing Administration (HCFA), which administers the Medicaid program, could help ensure health centers' continued ability to serve Medicaid beneficiaries and the uninsured by monitoring state Medicaid programs' compliance with federal requirements for reimbursing centers.

Since its reauthorization in 1990, the National Health Service Corps has expanded and now provides thousands of health care providers to underserved areas. However, it, too, could be more effective. For example, a shift of resources could help to provide more loan repayments. Also needed are an improved system to identify and measure areas' need for Corps providers, a better placement process, and coordination with other federal and state efforts to place providers in areas that need them.

HEALTH CENTERS HAVE BEEN A RELATIVELY STABLE SOURCE OF CARE FOR UNDERSERVED PEOPLE IN URBAN AND RURAL AREAS

Since they were established in the mid-1960s, community and migrant health centers have offered primary and preventive health services provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through arrangements with other providers. A distinguishing feature of centers is that they provide Aenabling services that help patients gain access to health care, such as outreach, translation, and transportation. Most health centers operate facilities at several locations. Health centers are typically managed by an executive director, a financial officer, and a clinical director. A health center's community board, with a majority of members who are health center patients, provides policy oversight and has the authority to hire and fire the center's executive director.

Most Health Centers Stay in Business, Operating More Sites and Serving More Patients

The number of health centers remained stable from 1996 to 1998, at a little over 600 grantees. During this 3-year period, 44 centers failed to qualify for continued federal grant funding, but a similar number of new centers received funding. The average number of sites each health center operated increased from 4 to 5, and the total number of people served by health centers increased from 7.7 million to 8.3 million. In 1998, approximately 57 percent of health center grantees were located in rural areas, but the number of people served in rural and urban areas was approximately the same.

According to HRSA, about 40 percent of all health centers are doing well, maintaining sufficient staff capacity and serving a growing number of patients. About 50 percent are considered viable but are experiencing some operational problems. The remaining 10 percent are struggling to survive, and they typically have major financial problems, such as a large deficit, vacancies on their management team, or significant losses or turnover of core health providers. Each year, a small proportion of centers—about 2 percent—actually lose federal funding, typically due to poor financial performance. Centers' degree of success is not necessarily constant. Health centers that excel for a few years sometimes develop problems, and some having problems have improved their situation and become more successful.

Community and migrant health centers provide mostly primary health care, averaging four encounters per patient per year; they are also required to provide services that enable center users to gain access to care, such as transportation and translation services. We found that the average number of enabling service encounters reported by health centers dropped from 1996 to 1998, and health centers in some states have reported eliminating or reducing transportation, education, and counseling services.

Health Center Patients Are Predominantly From Vulnerable Populations, and Many Lack Health Insurance

A high proportion of health center patients are from vulnerable populations. Health centers report that overall, their user population is poor or low income, with 65 percent having incomes at or under the federal poverty level. Health centers also serve a disproportionate number of minorities. Almost one-third of health center pa-

tients are Hispanic, and one quarter are black. Centers primarily serve children and women of childbearing age. Centers also report that they provide care to migrant and seasonal farmworkers and that almost one in five of their patients need an interpreter to use their services.

Reflecting the national growth in the uninsured, the number of uninsured people receiving care at health centers increased 10 percent between 1996 and 1998, with the share of center patients lacking health insurance reaching 40 percent. The proportion of Medicaid patients declined slightly. Medicaid was, however, the largest source of coverage for health center users with health insurance; about one-third of health center users in 1998 were Medicaid beneficiaries.

Medicaid Has Become the Largest Source of Health Center Revenue

In 1998, health centers reported revenues of almost $3 billion. Medicaid was the largest funding source, representing about 35 percent of the total. HRSA's health center grants were the second largest source, representing 23 percent of the total. The proportion of revenue that comes from Medicaid has increased gradually, while the proportion of health center revenue that comes from federal grant funding has steadily declined.

In response to the increase in the uninsured and other challenges facing health centers, the Congress passed legislation to substantially increase the health center program budget for the last 2 fiscal years. Federal funding for health centers increased by $100 million in fiscal year 1999 and another $99 million in fiscal year 2000. Over 80 percent of the existing health centers received an increase in funding in 1999, and HRSA also allocated funds for 19 new community and migrant health centers and gave existing centers funds to open 27 new sites.

Growth of Medicaid Managed Care and Changes in Payment Policies Can Affect Health Centers

The increase in Medicaid's use of managed care and changes in Medicaid payment requirements can affect the number of Medicaid beneficiaries health centers treat and centers' Medicaid revenues. While our analysis of health center data shows that, nationally, the average number of health center Medicaid patients has increased over the past several years, the number of Medicaid patients has declined at health centers in 20 states and territories. Our analysis also indicates that the effect of Medicaid managed care on health center revenue varies by state and individual center, reflecting differences in payment practices among states and managed care organizations. According to directors of primary care associations in several states with Medicaid managed care programs, the implementation of managed care has resulted in the loss of Medicaid revenues at some health centers.

Almost all state and territorial Medicaid programs serve at least some beneficiaries through managed care plans. Moreover, between 1991 and 1998, the proportion of Medicaid beneficiaries enrolled in managed care increased from 9.5 percent to 54 percent. Under waiver authority of section 1115 or 1915(b) of the Social Security Act, states may require people eligible for Medicaid to enroll in a managed care plan. In addition, section 4701 of the Balanced Budget Act of 1997 (BBA) gave states the ability to implement mandatory managed care programs without obtaining a special waiver from HCFA if they meet certain requirements. In these programs, states typically pay managed care organizations a fixed monthly capitation fee to provide all covered services needed by enrolled beneficiaries. Therefore, to serve Medicaid beneficiaries in managed care, health centers must either contract with a managed care organization to provide services to its enrollees or form their own managed care organization.

Health center revenue may also be affected by states' implementation of statutory Medicaid requirements for reimbursing community and migrant health centers and other federally qualified health centers, as well as waivers of those requirements given to states. Beginning in 1989, Medicaid was required to reimburse federally qualified health centers at 100 percent of their reasonable costs. In September 1999, 15 states had been exempted, under their section 1115 waivers, from the requirement to provide 100-percent cost-based reimbursement for these centers. The terms and conditions of a majority of such waivers included a provision that centers be reimbursed on a cost-related or risk-adjusted basis. Section 4712(a) of BBA allowed all states to gradually reduce their reimbursement levels for health centers through fiscal year 2004; section 603 of the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 modified these provisions, slowing the phase-down.

Few states have made long-term decisions about how to pay health centers that provide services to Medicaid patients in light of the changes in the federal requirement for cost-based reimbursement. Five states have passed legislation ensuring

100-percent payment, 25 other states will continue 100-percent reimbursement for at least fiscal year 2000, but most have not made any decisions about what payment method they will use in the long term. Seven states have already reduced their reimbursement to the BBA floor of 95 percent of costs.

If a managed care organization payment for a Medicaid service is insufficient to meet a health center's costs, states are required under section 4712(b) of BBA to make up a portion of the difference with a supplemental, or "wraparound," payment. The payment amount, when combined with the managed care payment, should equal the statutorily required percentage of costs—for example, 95 percent in fiscal year 2000. Some states with large Medicaid enrollments, including California and Florida, delayed giving health centers the required supplemental payments established by BBA until HCFA intervened or until health centers filed suit.

Timely Responses to Changes in the Health Care Environment Contribute to Centers' Success

Individual health centers face varying degrees of pressure from changes in the health care market, such as increased competition for Medicaid patients. Through our site visits and discussions with HRSA and health center officials, we found that centers that have taken appropriate and timely actions to respond to these changes are more likely to succeed. Successful centers typically have management teams with strong business skills and dedication to carrying out the health center mission, as well as boards that actively perform their policy and oversight roles.

Increasingly, health centers are trying to compete for patients and improve their operations by forming partnerships or networks with other health care providers. Networks can enable centers to share expertise and resources—such as information systems or fiscal operations—control costs, or improve the quality of clinical services. For example, a Florida network consisting of four health centers and one homeless health center integrates administrative, fiscal, information system, clinical, and program planning and development services. Participating centers have improved their efficiency by sharing four major managerial positions and a centralized automated information system.

Effectively addressing the growth of managed care is another factor critical to some health centers' success. While some health centers participate in managed care by contracting with managed care organizations, others have formed their own managed care plans, either individually or in networks with other health centers or other health care providers. As of June 1999, 25 health center managed care plans in 18 states served almost 959,900 members.

HRSA officials and others knowledgeable about health centers believe that the more successful centers know how to attract patients with diverse payment sources, including those with private and public insurance. These centers also pursue a wide variety of revenue sources—such as private donations, foundation grants, or local government funding—to pay for services and facilities. Good billing, collection, and reporting systems help to maximize collections from these various revenue sources.

Many health centers are also seeking accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), believing this will improve their competitiveness. HRSA is encouraging all centers to take this action. As of August 1999, 124 health centers had received accreditation. Health center directors and HRSA officials believe that preparing for and going through the accreditation process are valuable experiences because they can improve the quality of services and staff commitment to high standards. Some center managers also believe that achieving accreditation gets them recognition from other providers as well as consumers and that it will improve their ability to negotiate favorable contracts and rates with managed care organizations and other providers. However, evidence of whether JCAHO accreditation improves health centers' bargaining position is just beginning to be reported.

Poor Management Has Contributed to Some Health Centers' Problems

We learned that health centers that do not respond appropriately to changes in the health care market are more likely to have serious problems. Some centers have lost market share as the demographics or socioeconomic status of their communities have changed or as competition from other providers has increased. Others have unfavorable contracts with other providers and managed care organizations, leading to lost revenues.

Most of the health centers that we reviewed and that were defunded or identified by HRSA as having serious operational problems had management that demonstrated a lack of understanding of their centers' business operations. In general, the centers operated inefficiently, resulting in expenses that exceeded income. When faced with difficult financial situations, the managers of these centers did not take

the necessary actions to control expenditures and restore their center's financial viability. In some cases, the center's board had not provided active oversight, including exercising its responsibility to replace the health center leadership.

Some HRSA Strategies to Help Health Centers Show Promise; Others Need Improvement

The health center program is administered by HRSA's Bureau of Primary Health Care. HRSA provides grants to health centers to support the provision of health care and enabling services. HRSA also provides grants to state and regional primary care associations—private, nonprofit membership organizations of health centers and other providers—and has cooperative agreements with primary care offices, federally supported entities within state health agencies. HRSA coordinates with HCFA, which administers the Medicaid and Medicare programs, on issues concerning health centers.

To help health centers strategically respond to changes in the health care environment, HRSA has provided grants to states' primary care associations to conduct marketplace analyses that help identify areas where new or expanded services would improve access. For example, a marketplace analysis in Colorado found that one area had no doctors accepting Medicaid patients or offering care on a sliding-fee basis. This led to an existing health center grantee using HRSA funding to open a new site in the underserved area in 1999.

To encourage health center participation in managed care, HRSA's Integrated Services Development Initiative gives health centers grants to help them develop comprehensive integrated delivery systems and practice management networks. HRSA also provides training, technical assistance, and financial support to help health centers participate in managed care. As health centers enter into managed care contracts, they need to know their costs, understand their competition, and carefully consider how much financial risk they can assume. While some health center managers have found HRSA's courses on managed care helpful, others told us that HRSA's training on negotiating managed care contracts could have been more timely and provided more specific information to help them negotiate contracts.

In addition, HRSA does not have a systematic mechanism to allow all health centers to share information and learn from one another. Consequently, many centers work on developing solutions to the same problems for which other centers have already devised successful strategies. For example, we learned of two health centers that independently developed a productivity measurement system. Therefore, we recommended in our report, issued today, that HRSA establish a best practices program to facilitate health centers' sharing of information.

HCFA also has responsibilities for helping to ensure that vulnerable populations have access to health care services. One of HCFA's responsibilities is ensuring that state Medicaid programs properly reimburse health centers. If states do not comply with federal payment provisions, health centers' ability to serve both Medicaid patients and uninsured people can be impaired. Over the years, HCFA has sent state Medicaid agencies instructions on how to implement health center payment changes, such as those established by BBA. HCFA has not routinely reviewed state operations to determine their compliance with the laws affecting health centers; instead, it typically responds to issues brought to its attention. In the report we issued today, we also recommended that HCFA monitor state Medicaid programs' compliance with federal payment requirements and intervene when states do not meet their financial obligations to health centers.

HRSA Monitors Health Center Performance, but Timely Problem Identification and Intervention Are Difficult and Data Collection Needs Improvement

HRSA assesses each health center's financial health, growth in patient population, staffing capacity, and competitiveness in the health care market. It considers several characteristics to be markers of success, such as having growth in the number of patients and a stable, high quality management team. Conversely, it considers to be at risk and more closely monitors centers that have a high budget deficit, spend their HRSA grant too quickly, or have significant management or medical team vacancies.

To understand how health centers are operating and to evaluate their overall performance, HRSA each year collects administrative, demographic, financial, and utilization data from each center through its Uniform Data System (UDS). While UDS gathers some useful information, it also has weaknesses and limitations. Instructions to centers have not always been clear, data editing and cleaning processes have not always worked well, and some centers have failed to report certain data elements or have reported them very late, even though complete and accurate reporting is a condition of receiving a HRSA grant.

UDS also has limitations for monitoring and evaluating performance. The financial data in UDS cannot provide an accurate indication of an individual center's financial status because costs are reported on an accrual basis, while revenues are reported on a cash basis. This makes it difficult to estimate the extent to which centers' revenues cover costs. The required independent financial audit is perhaps the best source of accurate information on a health centers' fiscal health, but there are delays in HRSA's receipt of the financial audits. HRSA officials have taken steps to improve UDS and the collection of performance information. Our report recommends that HRSA further improve the quality of UDS data, enforce the requirement that every grantee report complete and accurate data, and use more accurate and timely financial data to monitor performance.

Another method HRSA uses to monitor health center performance is its Primary Care Effectiveness Review. These reviews, which include on-site visits, are a mandatory part of the grant renewal process, which occurs every 3 to 5 years. Health centers with identified problems are expected to take corrective actions before receiving additional grant funding. When necessary, HRSA sends consultants to help centers develop a financial recovery or action plan that can help them solve their financial or operational problems. However, sometimes HRSA's interventions have been too late to make a difference. The agency often goes through a lengthy process before deciding whether to continue funding a particular health center or pursue other alternatives for providing primary care services in the area, such as a merger with another grantee.

For centers seeking JCAHO accreditation, HRSA has been able to obtain information from the JCAHO survey to help monitor centers, but the JCAHO process does not provide HRSA with all the information it needs on health centers' fiscal, information system, and other operations. HRSA currently supplements the JCAHO survey with its own fiscal and information system review protocols.

CORPS REAUTHORIZATION PROVIDES OPPORTUNITIES FOR IMPROVEMENTS

At the end of fiscal year 1999, the National Health Service Corps had 2,526 physicians, dentists, nurse practitioners and other providers serving in shortage areas. Since 1990, when the Corps was last reauthorized, funding for its scholarship and loan repayment programs has increased sevenfold, from $11 million in 1990 to $78 million in 1999. Nevertheless, the Corps continues to be challenged to use these dollars as effectively as possible in meeting its mission, as year after year, it receives more requests from communities for health professionals than it can meet.

Loan Repayment Program Has Favorable Costs and Benefits

In past work, we have addressed which approach works betterCscholarships or loan repayments. Under the scholarship program, students are recruited before or during their health professions trainingCgenerally several years before they begin their service obligation. Under the loan repayment program, providers are recruited after they complete their training. The scholarship program provides tuition and other support for each year while in school, while the loan repayment program repays up to $25,000 of student debt for each year of service provided. Under the Public Health Service Act, at least 40 percent of the available funding must be for scholarships.

We found that, for several reasons, the loan repayment program is generally the better approach to provide health care professionals to shortage areas:

The loan repayment program costs less. On average, a year of service by a physician under the scholarship program costs the federal government over $43,000 compared with less than $25,000 under the loan repayment program. A major reason for this difference is the time value of money—7 or more years can elapse between when a physician receives scholarship assistance and begins to practice in an underserved area. In the loan repayment program, however, the federal government does not pay until after the service has begun.

Loan repayment recipients are more likely to complete their service obligations. This is not surprising when one considers that scholarship recipients enter into their contracts up to 7 or more years before beginning their service obligation, during which time their professional interests and personal circumstances may change. Twelve percent of scholarship recipients breached their contract to serve between 1980 and 1999, compared with about 3 percent of loan repayment recipients since that program began.

Loan repayment recipients are more likely to continue practicing in the underserved community after completing their obligation. How long providers remain is not clear, because the Corps does not have a tracking system in place. However, we analyzed data for calendar years 1991 through 1993 and found that 48 percent of loan repayment recipients were still at the same site 1 year after fulfilling their ob-

ligation, compared to 27 percent for scholarship recipients. Again, this finding is not surprising. Because loan repayment recipients do not commit to service until after they have completed training, they are more likely to know what they want to do and where they want to live or practice at the time they make the commitment.

For these reasons, we suggest now—as we did in our 1995 report on the Corps—that the Congress consider modifying the current requirement that scholarships receive at least 40 percent of the funding. Besides being generally less costly and having favorable benefits, the loan repayment program allows the Corps to respond more quickly to changing needs. If demand suddenly increases for a certain type of health professional, the Corps can recruit graduates right away through loan repayments. By contrast, giving a scholarship means waiting for years for the person to complete training.

This is not to say that the scholarship program should be eliminated. Because scholarship recipients have fewer choices of where they can fulfill their service obligation, they could be directed to the neediest sites. However, our work indicates this advantage has not worked out in practice. For Corps providers beginning practice in 1993-94, we found no significant difference, on average, between scholarship and loan payment recipients in the priority of their service location. This suggests that the scholarship program should be tightened so that it focuses on those areas with critical needs that cannot be met through loan repayment. In this regard, one way to increase the number of providers in high priority areas might be to reduce the number of sites that scholarship recipients can choose from, so that the focus of scholarships is clearly on the neediest sites. While placing greater restrictions on service locations could potentially reduce interest in the scholarship program, the program currently has almost seven applicants for every scholarshipCsuggesting the interest level is high enough to allow for some tightening in the program's conditions. If that should fail, additional incentives to get providers to the neediest areas might need to be explored.

Current System for Identifying Need Could Be Improved

While the Public Health Service Act states that the purpose of the Corps is to eliminate health manpower shortages in health professional shortage areas, measuring the extent of these shortages is problematic. Under current regulations, HHS considers a health professional shortage area (HPSA) generally to be an area, population group, or facility with less than one primary care physician for every 3,500 persons. In December 1999, HHS identified 2,862 primary care HPSAs. To eliminate these HPSA designations, HHS identified a need of over 5,500 full-time physicians.

Over the past 5 years, we have identified and reported on a number of problems with HHS' process for determining whether an area is a HPSA. In addition to problems with the timeliness and quality of the data used, we found that HHS' current approach does not count some providers already working in shortage areas. For example, it does not count nonphysicians providing primary care, such as nurse practitioners, and it does not count Corps providers already practicing in the shortage area. As a result, the current HPSA system tends to overstate the need for more providers, limiting HHS' ability to identify the universe of need and prioritize areas.

Recognizing these flaws, HHS has been working on ways to improve the designation of HPSAs, but the problems have not yet been resolved. After studying the changes needed to improve its HPSA designation system for most of the 1990s, HHS published a proposed rule in the Federal Register in September 1998. This proposal included provisions to update the designations regularly and count nonphysician practitioners. The proposed rule generated a large volume of comments and a high level of concern about its potential effect. In particular, people in some areas were concerned that the new criteria would result in their losing their HPSA designations. In June 1999, HHS announced that it would conduct further analyses before proceeding.

The controversy surrounding proposed modifications to the HPSA designation system may be due, in large part, to its use by other programs. Originally, the system was only used to identify an area that could request providers from the Corps. Today, many federal and state programs—including efforts unaffiliated with HHS—use the HPSA designation in considering program eligibility. These areas want the HPSA designation in order to be eligible for other programs such as a 10-percent bonus on Medicare payments or cost-based reimbursement under the Rural Health Clinic program.

Current Placement Process Could Be Improved

Related to the need to improve the current system for identifying areas eligible for Corps providers, it is also critical that the Corps implement an effective system for placing providers in those areas. There are not enough Corps providers to fill

all of the vacancies approved for them. In fiscal year 1999, for example, HHS determined that 828 primary care HPSAs requesting providers had vacancies meeting the criteria for being listed as a place where a Corps provider could serve. Some of these HPSAs needed multiple providers. That same year, the Corps could fill only a fraction of these vacancies.

One question we have examined is whether providers are being placed in as many needy areas as possible. In analyzing placements for 1993, we found that at least 22 percent of shortage areas receiving Corps providers received more providers than needed to increase their provider-to-population ratio to the point that their HPSA designation could be removed, while 65 percent of shortage areas with Corps-approved vacancies did not receive any providers. Of these latter locations, 143 had unsuccessfully requested a Corps provider for 3 years or more. The Corps has subsequently made improvements in its procedures and has substantially cut the number of HPSAs not receiving providers. However, that number is still above 380, and some HPSAs can still receive more than enough providers to remove their shortage designation.

HHS officials have said that in making placements, they need to weighCin addition to assisting as many shortage areas as possible—the viability of the site and the chance that a provider might stay beyond the period of obligated service. However, because the sites that are on the vacancy list have to meet Corps requirements for infrastructure and salary, viability should not be an issue for those locations. And while we agree that retention is a laudable goal, the effect of the Corps' current practice is unknown because the Corps does not track long-term retention. We suggest that the Congress consider clarifying the extent to which the program should try to meet the minimum needs of as many shortage areas as possible and the extent to which additional placements should be allowed to try to encourage provider retention.

Placement Efforts Need Better Coordination with Waivers for J-1 Visa Physicians

Underserved communities are frequently turning to another method of obtaining physiciansCattracting non-U.S. citizens who have just completed their graduate medical education in the United States. These physicians generally enter the United States under an exchange visitor program, and their visas, called J-1 visas, require them to leave the country when their medical training is done. However, the requirement to leave can be waived if a federal agency or state requests it. A waiver is usually accompanied by a requirement that the physician practice for a specified period in an underserved area. In fiscal year 1999, nearly 40 states requested such waivers. They have been joined by several federal agenciesC particularly the Department of Agriculture, which has requested waivers for physicians to practice in rural areas, and the Appalachian Regional Commission, which has requested waivers to fill physician needs in Appalachia.

Waiver placements have become so numerous that they now surpass Corps physicians. In September 1999, over 2,000 physicians had waivers and were practicing in or contracted to practice in underserved areas, compared with 1,356 Corps physicians. The number of waiver physicians is now large enough to total over one-third of the full-time primary care physicians needed to eliminate HPSA designations nationwide.

Although coordinating Corps placements and waiver placements has the obvious advantage of addressing the needs of as many underserved locations as possible, it is not occurring. As a result, some areas have ended up with more than enough physicians to remove their shortage designations, while needs in other areas have gone unfilled. There are two main reasons for the problem:

HHS does not support the waiver approach as a sound way to address underservice needs in the United States. The agency's position is that physicians should return home after completing their medical training to make their knowledge and skills available to their home countries. As a result, although the states and other federal agencies are using waivers to address underservice, HHS does not have a system to take these placements into account in determining where to put Corps physicians.

This sizeable domestic placement effort is rudderless. Even among those states and agencies using the waiver approach, no agency has responsibility for ensuring that placement efforts are coordinated. While some informal coordination may occur, it remains a fragmented effort with no overall program accountability.

As the Congress considers reauthorizing the Corps, it has the opportunity to address these issues. As we previously reported, we believe that the prospects for coordination could be enhanced by action in two areas. First, clarify how the use of waivers for these physicians fits into the overall federal government strategy for addressing underservice. This should include determining the size of the J-1 visa waiv-

er program and establishing how it should be coordinated with other federal programs. Second, designate leadership responsibility for managing the J-1 visa activity for physicians as a distinct program.

CONCLUDING OBSERVATIONS

Our work has shown that while the Community and Migrant Health Center program and the National Health Service Corps programs have provided valuable services to vulnerable populations, steps could be taken to make them more effective. At the same time, we would like to point out an overarching issue that our work has consistently identified: HHS systems for identifying underservice need immediate attention. While HHS has been studying these issues for years, the systems are currently of little help in accurately identifying who is underserved and why and in measuring the extent to which a program, once instituted, is alleviating access problems. We believe HHS needs to gather more consistent and reliable information on the changing needs for services in underserved communities. Until then, determining whether federal resources are appropriately targeted to communities of greatest need and measuring their impact will remain problematic.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions you or other members of the Subcommittee may have.

PREPARED STATEMENT OF THOMAS M. DEAN, M.D.

Chairman Frist and members of the Senate Public Health Subcommittee: I first want to thank you for inviting me to testify today about the National Health Service Corps a program that has significantly impacted my rural South Dakota community. I come here today to ask you to ensure Congress reauthorizes the National Health Service Corps program this year. As I am sure you are aware, this important program's current reauthorization expires at the end of this fiscal year. Given the strict fiscal constraints in which this Congress is working, I believe any program not reauthorized faces an uncertain destiny. Should this program not be reauthorized, and subsequently unfunded, millions of Americans, including Medicare beneficiaries, will be faced with the reality of not having access to basic primary health care services.

During the National Health Service Corps' 26-year history, the program has placed more than 20,000 health care providers in some of the most difficult-to-place inner city, rural and frontier communities, thereby increasing the availability of primary, oral and behavioral health care services to 4.6 million people. Currently, over 2,400 dedicated Corps primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, and oral and mental health practitioners are practicing in underserved communities.

Unfortunately, many of the individuals and families served by National Health Service Corps providers are unaware that their practitioner was made available to them through the Corps program. For this reason, I do not believe the National Health Service Corps program has received the grassroots and congressional support it deserves.

The fact is a large percentage of inner city, rural and frontier residents remain without access to adequate primary health care services despite the successful work of the Corps. The 4.6 million individuals currently receiving care from Corps clinicians represent only 20 percent of our nation's underserved population. It is estimated that 20,000 additional NHSC clinicians would be needed to eliminate the 2,821 Health Professional Shortage Areas (HPSAs), 1,116 dental HPSAs, and 629 mental health HPSAs now designated across the country.

Why has the Corps program not eliminated or reduced the number of shortage areas? First, the program has seen its funding significantly reduced and then level funded over the past ten years. Just last year, the Corps had to turn away half the underserved communities that requested a provider, because the program did not have the necessary funding to support additional clinicians. In addition, many of the HPSAs served by Corps clinicians are remote and the possibility of a practitioner staying beyond their service is not a possibility. In many of these remote and difficult-to-place sites, the only way in which access will remain constant is through the presence of the National Health Service Corps.

The National Rural Health Association believes that with reauthorization that includes appropriate reforms and increased appropriations, the National Health Service Corps can build upon its success in bringing a broad spectrum of health providers to practice in our nation's most underserved and needy communities.

I wanted to take the opportunity today to tell you about my personal experience with the National Health Service Corps program, both as a Corps provider and one running a site which hosts a number of National Health Service Corps clinicians.

I have experienced first hand the significant impact the Corps plays in providing access to care in rural South Dakota. In 1973, I signed up as a commissioned officer in the Corps this was before the Corps transitioned to the scholarship and loan repayment programs, which exist today. I actually began my active service in the Corps in 1975 when I completed residency and worked for 3 years in the small, rural town of Hyden, Kentucky. During this time, my wife Kathy went to midwifery school.

In 1978, Kathy and I returned to South Dakota and were the first staff hired for a new "Rural Health Initiative" project in Wessington Springs, Woonsocket and Plankinton. Of the five clinicians hired to start that project, three were National Health Service Corps officers. I am proud to share that two of those three Corps clinicians are still with the project today, twenty-one years later. During those twenty-one years, we have had four other NHSC clinicians in the practice, a total of four physicians and five midlevels. Today, three of the six providers practicing in our clinic were made available to us through the National Health Service Corps program.

Our practice is located in an area where it has been extremely difficult to recruit clinicians. If it were not for the Corps, I can say with complete sincerity that I do not believe the communities we serve would have had access to basic health care services nor would we have been able to build the practice into the fully integrated modern rural primary care system in which we take so much pride today.

We serve an extremely low-income, relatively isolated rural agricultural area with one of the highest proportions of elderly in the state of South Dakota. Since the start-up of our rural clinic, death rates from heart disease and cancer have declined, as has the rate of teen pregnancy. In addition, immunization rates have risen substantially. These significant changes in the health status of our community have been a result of many factors, but I am convinced that the presence of Corps clinicians has been a major contributor to the improved health of those living in our community. In my conversations with other National Health Service Corps clinicians around this country, the same holds true for many other communities served by the Corps.

The idea of small town practice—especially in more isolated areas—is intimidating to many newly trained practitioners. I know that my training was better oriented in this regard than many because of my participation in the Corps program. The beauty of the Corps is that it allows one to "try it out" with the support structure of the Corps to assist them. Through hands-on experience, physicians and other health care providers become comfortable with a setting be it inner-city or rural - which is quite different than that in which they trained, and are thus more willing to consider such a community as a long term endeavor.

In our practice, the NHSC allowed us to place clinicians in two counties which had been without a local source of primary care services for nearly twenty years. The program has been a success, and for the past twenty years those two communities have had continuous local access to primary care services—in one instance it is the same physician assistant providing that care who moved there when we began practicing in 1979.

Over the years we have used every available recruiting technique to locate physicians advertising, professional recruiters, mailings to residents, etc. However, the only consistently effective approach was the National Health Service Corps program. Our community is not unique in this regard. The reality is that there are many areas of this country that will always be hard-to-place sites. Without the Corps program, I believe that many of these communities would remain without access to basic health care services. For many providers it is the fact that these communities are so remote that it is not an attractive place to practice medicine and raise a family. The National Health Service Corps program provides financial incentives to American-trained practitioners through its scholarship and loan repayment programs to serve these communities.

Over the life of the National Health Service Corps, much has been made of the issue of retention of Corps clinicians in the sites where they are placed. Critics of the program have based their entire judgment of the success of the program on this single issue. Do we judge the success of the Peace Corps based on whether Peace Corps volunteers stay in the country where they served? Then why do we continue to judge the National Health Service Corps program based the retention of providers in the communities in which they serve beyond their Corps commitment?

I would submit that, though retention is unquestionably an important goal, it is not the sole determinant of the success of the program. By far the most important measure of success of the Corps program is whether underserved communities received health care they would not have received through conventional sources. That is clearly the case in our setting, and I believe in thousands of other National

Health Service Corps sites across the country. At the same time, I believe, with the National Rural Health Association, that retention must be a key component of the Corps program. However, retention can only be achieved through community assessment and site development efforts. Community assessment and site development are significant retention tools that must be a part of reauthorization legislation.

Because the National Rural Health Association is committed to the significant impact the Corps program has had in guaranteeing access to health care services to rural and frontier Americans, the NRHA, along with the American Psychological Association, has brought together a coalition of eighteen national provider organizations committed to the National Health Service Corps program. This coalition is currently working on a set of reauthorization recommendations that will provide the program with the tools and flexibility to further advance the Corps' ability to meet the needs of our underserved communities.

As part of reauthorization, several important issues must be considered in an effort to strengthen the current program. Such issues include, but are not limited to: authorizing increased funding to support a growing Corps; expanding community and site assessment and development; creating tools to increase retention of Corps clinicians beyond their required service; increasing interdisciplinary health care opportunities; and improving the scholarship and loan repayment programs to best meet the needs of underserved communities. In the coming weeks, the NRHA, and the coalition of provider organizations we have joined with, hope to bring to this Committee a set of recommendations that will assist you in crafting reauthorization legislation that will expand the National Health Service Corps program's efforts in providing access to the underserved.

While I understand this Committee does not have jurisdiction over this issue, I do want to be on record in stating the NRHA strongly supports a change in the Internal Revenue Code to exclude from gross income any amounts received under the tuition, loan payments, and related expenses portion of the NHSC scholarship and loan repayment programs. This ruling by the IRS has had dire consequences on the ability of the NHSC to attract potential scholars. In addition, the Corps has had to use its own limited funding to pay taxes on the scholarships and loan payments it makes on behalf of the clinicians that serve in the program dollars that should be directed toward providing access to those communities still in need. I would ask this Committee to communicate to the Senate Finance Committee, as well as the Senate leadership, its support for a change in the tax code.

We live in a time when commercialism and business priorities have come to dominate much of what we do in the caring professions. The National Health Service Corps, with its emphasis on "health" and on "service" is a wonderful opportunity for you ng clinicians to experience the rewards of providing care to people truly in need. Through that experience they are in a better position to understand the vital role they play in their profession and the need to maintain a focus on fundamental values of service and caring which are so easily neglected in today's commercial environment.

I feel deeply that the National Health Service Corps program has served a critical role in the development and sustainability of health services in my remote, rural community. Just as important, the program contributes greatly to the professional growth of the primary care, oral and behavioral health care professionals privileged to serve in its ranks. I join the NRHA and the countless other national organizations in urging this committee to ensure a stronger and expanded National Health Service Corps program for the future by reauthorizing this critically important program and working with appropriators to provide increased resources to the program so that it can meet the need of those inner-city and rural communities that continue to be underserved.

Prepared Statement of Bernard Simmons

Mr. Chairman and Members of the Subcommittee, my name is Bernard Simmons. I am the Executive Director of the Southwest Health Agency for Rural People, or SHARP, located in Tylertown, in the heart of southwestern Mississippi. I appreciate this opportunity to speak with you today, on behalf of the National Association of Community Health Centers, about the work of health centers and other safety net providers in caring for uninsured and underserved people in our rapidly changing health care system.

My testimony today will focus on three areas:

1. Health centers are doing the job expected of them by this Subcommittee and the Congress providing quality health services at low cost for millions of low-income Americans.

2. While every American and every health provider have been affected in some way by the dramatic and far-reaching changes that have swept across our health care system, few have been as profoundly affected as health centers and their fellow safety net providers, even as they actively participate in mainstream managed care arrangements.

3. Health centers need the continued support of this Subcommittee, and indeed of the entire Congress, in order to continue fulfilling their public policy mission and purpose.

HEALTH CENTERS ARE HIGH QUALITY, LOW COST, EFFICIENT PROVIDERS

A Background on Health Centers

Health centers today represent more than 35 years of federal, state, and local community investment in primary care infrastructure for medically underserved people and communities. Most community, migrant, homeless and public housing health centers receive grants under section 330 of the Public Health Service (PHS) Act, which is authorized by this Committee. Other community-based health centers are designated as Federally qualified health centers (FQHCs) under the Medicare and Medicaid laws because they meet all the requirements applicable to health centers that receive Federal grant assistance, but sufficient grant funds are not available to provide them with Federal support.

Health centers bring health care providers, services, and facilities to people living in low-income and medically underserved urban and rural communities with few or no other health care resources. The underlying goal of the federal health centers program—as authorized under section 330 of the PHS Act by this Committee—has been to help communities and their people to take responsibility for their health. Toward that end, the program has facilitated the flow of public and private resources, enabling the communities themselves to establish and operate health centers and to develop innovative efforts to meet the health needs of individuals in the communities they serve. Health centers have improved access to care and have reduced health care costs, while sustaining and enhancing the quality of care provided.

Health centers are, by law, located exclusively in rural and inner city communities that have been designated as medically underserved, because they have far too few primary care providers and poor health status indicators. Health centers must make their services available to all residents of their service area, within the limits of their resources.

A distinctive feature of health centers is that they are developed and run by people within their communities, and are staffed and managed by individuals who understand the needs of the people in their communities. Health center governing boards are composed of active registered patients and local community leaders, such as business owners, educators and residents who are committed to provide access to primary health care which meets the needs of their community. They are working together to make a difference.

Each local health center is unique in terms of the range of services it offers and its hours of operation, reflecting local decisions on how best to meet their patients' health care needs. At the same time, all of the health centers are subject to ongoing Federal monitoring of their cost-effectiveness, quality of care, and management at a level which is more stringent than that applied to any other provider. They are regulated by the Health Resources and Services Administration (HRSA) under the PHS Act grant program, and by the Health Care Financing Administration (HCFA) under the Medicare and Medicaid programs.

Health Centers Provide Services to Those Who Lack a Regular Source of Care

Health centers serve medically underserved Americans. In simplest terms, the medically underserved are people who cannot get care when they need it, and when it is most appropriate—to prevent the onset of a health problem or illness, or to diagnose and treat a condition in its earliest stages. The medically underserved span all ages and live in all communities, and include residents of rural areas and inner cities, the uninsured, low-income children, agricultural farmworkers, homeless individuals, persons with physical and mental disabilities, and persons with HIV and other communicable diseases. Last year, more than 1000 health centers served more than 11 million children and adults in 3200 communities across the country. More than 9 million people obtain care from health centers that receive funding from the federal health centers grant program, while another 2 million people receive care from designated FQHCs that do not receive grant funds.

Health center patients include: 4.5 million uninsured persons, 1 of every 10 uninsured Americans; 4.5 million children, 1 of every 6 low-income American children,

including 1 of every 5 low-income uninsured children (1.6 million); 4 million children and adults with Medicaid or CHIP coverage, 1 of every 9 Medicaid/CHIP recipients; More than 7 million people of color; and 5.6 million residents of rural communities, 1 of every 12 rural Americans.

Health centers also serve more than 600,000 agricultural farm workers and 500,000 homeless persons.

Because of factors such as poverty or homelessness, and other problems which permeate underserved communities, health center patients are at higher risk for serious and costly conditions (such as diabetes, hypertension, asthma, or high risk pregnancies) than the general population, and require unique health services not typically offered by traditional providers. My colleague, Robert Taube of Boston's Health Care for the Homeless Health Center, will speak more specifically to this key point as it applies to individuals who are homeless; and I would add that the same is true for other populations served by health centers, such as farmworkers.

Health center patients are predominantly members of low income working families, most of who have little else in the way of available health care. Their care is financed by a variety of sources. The federal health center grants provide, on average, less than 28 percent of a health center's budget. Medicaid and CHIP payments account for about 34% percent, on average, of a health center's budget. State and local government support, and private donations, provide 16 percent of health center revenues nationally, while 8 percent comes from private insurance, and 7 percent from Medicare. Every health center patient contributes to the cost of his or her care, and on average, 7 percent of income comes from patient fees. These averages will vary for each health center, depending on the financing sources available to people in the local community.

Health Centers Provide Care that is Appropriate for the Underserved

Health centers are community owned and operated businesses—professional health care organizations providing a comprehensive range of high quality preventive and primary health care under one roof, in a "one stop shopping" system. We offer 24 hour care, both for prevention and for treatment of illness or injury, and in addition provide diagnostic laboratory and x-ray services, as well as prescribed medications in many cases. Health center clinicians make referrals to specialists and admit and follow their patients in the hospital, when necessary. Health centers provide continuous care to their patients, regardless of changes in their insurance coverage or health status.

For the medically underserved, however, access to care often includes other factors in additional to the ability to visit a physician's office. Studies show that the underserved are less likely to seek or use health care services, even when they appear to be available, and are more likely to seek primary care services at inappropriate settings, such as the hospital emergency room. Health centers work hard to counter this tendency.

Health centers provide a variety of additional services to make their care more accessible for the underserved. Outreach services provide individuals and communities with information on the availability of appropriate services and how to obtain them, and encourage their use. Health centers address geographic inaccessibility, such as barriers of time and distance and the lack of available and affordable public or other transportation by providing transportation services to enable patients to keep their appointments, both at the health center, and with specialists and hospitals.

Health centers often organize the provision of services to provide access to care at times, and in locations, that take into account the needs of medically underserved populations. For example, health centers provide labor camp or worksite based services for agricultural farmworkers during evening or late night hours. For homeless persons, health centers provide services in homeless shelters or mobile clinics in vans at street corner locations.

Many of the medically underserved come from different cultures and have primary fluency in languages other than English. Health centers provide translators, often in several languages, to enable providers to reach a critical understanding of significant cultural perceptions and their effect of health care practices of individuals from other cultures.

Health centers are cost-effective and efficient

Health centers are one of the best health care and taxpayer bargains anywhere. The combination of locally responsive health care delivery and consistent federal oversight has proved to be a winning formula. Health centers provide comprehensive services to their patients at an astonishingly low cost. The average total cost

of health center services amounts to less than $350 annually—less than $1 a day—for each person served.

Dozens of studies and reports show that health centers substantially improve the health of individuals in their communities and provide care in a highly cost-effective manner. The impacts health centers have had on the health of individuals in their communities include lower hospital admission rates, shorter lengths of stay and less inappropriate use of emergency room services, significantly lower infant mortality rates and reduced incidence of low birth weight, higher childhood immunization rates, and better use of preventive health services (like Pap smears, mammography, and glaucoma screening), resulting in lower rates of preventable illnesses.

Several studies over the last decade have found that Medicaid patients who regularly use health centers receive care of equal or greater quality and cost significantly less than those who use private primary care providers, such as HMOs, hospital outpatient units or private physicians. For instance:

In California, health center patients were 33% less expensive overall (controlling for maternity services), and had 27% less total hospital costs. (Center for Health Policy Studies, 1993)

In Maryland, health center patients had lowest total payments; lowest ambulatory visit cost; lowest incidence of inpatient days; and lowest inpatient day cost. (Johns Hopkins Univ School of Public Health and Hygiene, 1993)

In New York, health center patients were 22-30% less expensive overall, and had 41% lower total inpatient costs. Diabetics and asthmatics who were regular health center users had between 44% and 62% lower inpatient costs (Center for Health Policy Studies, 1994)

And two separate system-wide studies of thousands of Medicaid patient medical records in Maryland found that:

Health centers consistently scored at or near the highest in 21 separate measures of quality assessment, even though their costs of care were among the lowest of the various provider types reviewed; and

Health centers scored highest among all providers for the proportion of their pediatric patients who had received preventive services, including immunizations (JAMA, 1994; and Public Health Management Practice, 1995)

These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular documenting their substantial savings to state Medicaid programs. The record is clear that health centers provide quality, comprehensive primary care to some of the hardest-to-reach patients in the health system at a price second to none.

Health Centers Want to Continue to Serve

Thousands of communities across the country today experience continuing acute shortages of cost-effective preventive and primary health care service locations. At the same time, private market and public efforts to control costs are making it increasingly difficult for other providers to continue offering care to those without coverage. In this light, the health center program is today more critical than ever to the success of the American health care system, because they are the best and most affordable and cost-effective way to get quality health care to those who need it most. At the same time, however, the 4.5 million uninsured people whom health centers are able to reach account for only 10 percent of the nation's uninsured, and less than one-fourth of the 20 million uninsured Americans who otherwise would have no regular source of care.

Congress gave us a mission to expand access to health care for Americans in medically underserved areas. Yesterday, the primary challenges that faced us were untreated childhood illnesses such as inner ear infections and strep throat and adult illnesses such as diabetes and hypertension. Today, we are meeting the growing demand of individuals in local communities for care for acute and chronic illnesses, maternity services, and, in addition, care for re-emergent tuberculosis and other contagious diseases, community and family violence and associated trauma, HIV infection, teen pregnancy, and alcohol and substance additions. We are ready to continue our partnership with you in responding to the needs of those residing in the urban and rural communities we serve.

HEALTH CENTERS AND THE CHANGING HEALTH CARE SYSTEM

America's healthcare system is in the midst of sweeping change, largely market-driven and focused principally on containing and reducing the cost of care. The hallmarks of this change over the past several years have been the greatly increased use of managed care—both for commercially-insured individuals and for those covered by Medicaid and other public programs -and intensified competition among providers, leading to at least temporarily lower costs as managed care plans demand

substantial discounts on payments for their enrolled populations and providers accept the lower payments in order to remain viable. The vast majority of health care providers—including all health centers—are fully participating in managed care systems, and thus—like the 150 million Americans who are enrolled in those systems—are directly affected by the changes. However, unlike most other health care providers, health centers and their fellow safety net providers (those providers legally obligated to provide care to persons who cannot afford to pay, such as public hospitals and local public health agencies) have also been severely affected by other trends that most other providers have been able to avoid. These include:

The rapidly escalating number of individuals who are uninsured. As of late 1998, more than 44 million people were uninsured, nearly one of every 5 non-elderly Americans. Sixty percent of all uninsured Americans are members of low-income families. Despite the current economic boom and record unemployment rates, the number of uninsured people has grown by more than 5 million over the last 5 years, and experts project that the number will reach 60 million over the next decade if nothing is done, even if the economy remains exceptionally healthy. More than 1 million of these uninsured people have been added to health centers' patient rolls over the past few years, accounting for more than half of all new patients served over that period.

The continuing loss of Medicaid coverage among eligible low-income women and children. More than 2 million former Medicaid recipients have lost coverage over the past two years, even as they or a family member gained employment, because of the delinking of Medicaid coverage from welfare benefits. Even with the new State Child Health Insurance Program (CHIP) that today covers nearly 2 million children, more children are uninsured today than in 1995. Among the 4.5 million children and adolescents served by health centers, more than 1.6 million (36 percent) are uninsured—despite the fact that virtually all of these children are from low-income families with incomes below twice the federal poverty level. If all of the 1.6 million children and adolescents served by health centers were appropriately enrolled in Medicaid or CHIP, health centers could use the Federal grant dollars being spent to care for them to care for an additional 1.6 million uninsured people.

There are significant barriers to enrolling eligible individuals in Medicaid and CHIP. Of particular concern here is the failure—and oftentimes outright refusal—of most States to abide by current law requiring the outstationing of Medicaid eligibility and enrollment workers at health centers and at safety net (disproportionate share) hospitals. We have documented this serious problem in a recent letter to HCFA, a copy of which is attached to my statement. I might note that the frustrations involving attempts to enroll people in the Medicaid and CHIP programs for which they qualify are not limited to safety net providers alone. A recent survey of low-income families, conducted by the Kaiser Commission on Medicaid and the Uninsured, found that fully two-thirds of the eligible-but-not-enrolled individuals surveyed had attempted to enroll their children in these programs, without success, due principally to state administrative and bureaucratic barriers (National Survey of Barriers to Medicaid and CHIP Enrollment, February 2000).

The decline in charity care by non-safety net providers. As managed care has extended its reach in local communities, financially-pressed providers have lost the ability to shift the costs of uncompensated care to other payers, causing many to reduce or even eliminate completely the provision of charity care to those unable to pay. A recent study found substantially lower levels of charity care among physicians who were heavily involved with managed care or who practiced in communities with high managed care enrollment (exceeded only by the almost non-existent level of charity care among physicians who refuse to participate in managed care) resulting in an "increased burden on an already fragile safety net" (Cunningham, JAMA, November 1999).

The cumulative impact of these trends has nowhere been felt more profoundly than among health centers and their fellow safety net providers. A survey of health centers conducted by NACHC last summer found that more than 80 percent of all centers had increased the number of uninsured persons served, more than two-thirds of centers said that many people had lost Medicaid coverage locally, and 60 percent reported that local charity care levels had fallen markedly. It should come, then, as no surprise that many health centers are financially pressed, and some are struggling to keep their doors open, in these increasingly difficult times.

Yet even with these pressures, health centers all across the country have taken steps to form networks and managed care plans with other local providers, to negotiate subcontracts with other managed care plans, and to develop the financial, legal and business acumen necessary to function effectively in managed care. Health centers do play an important role in managed care—especially for Medicaid and CHIP-enrolled populations—because, like other managed care organizations, they are: a

first point of entry for their patients into the health care delivery system; experienced in the management of health care costs, since they must run their programs within a limited annual budget; and managers of care to keep their patients health and out of costly emergency rooms, hospitals, and specialists' offices.

Almost three-fourths of all health centers are participating in managed care as subcontracting providers to managed care plans, serving more than 2.4 million managed care enrollees. Health center-formed managed care organizations (MCOs) now operate in some 20 states, with more than 800,000 enrollees; in 12 states, these MCOs rank among the top 3 in terms of market share. Yet most of these MCOs now report that the states have reduced their capitation rates significantly, and many say that the new rates are insufficient to cover their costs, a claim that is borne out by the growing withdrawal of large commercial managed care organizations from the Medicaid managed care market in response to payment rates they deem unsufficient.

On a more local level, health centers have joined with each other and with other local providers to form integrated service networks to coordinate and improve their purchasing power or to better organize the continuum of care, especially for those who are uninsured. For example, 6 health centers in southwestern Mississippi have come together to expand health care access for the uninsured in our area. These efforts have encountered two major barriers:

An increasing difficulty securing needed services for their uninsured patients from local community hospitals and medical specialists, as those providers react to reduced payment rates by severely restricting the care they provide to individuals who are unable to pay.

Problems establishing perfectly legitimate agreements with local providers who are willing to provide such care, and thus to both enhance access to important services for health center patients and produce savings of federal grant dollars, without running afoul of the fraud and abuse restrictions in the Social Security Act. I might note that our National Association—and several Members of Congress—have urged the HHS Inspector General to provide a 'safe harbor' for arrangements of this sort, which would assure savings of federal grant dollars and/or expand health care access and services for health center patients. After 6 years, there is no resolution of this request to date.

HEALTH CENTERS NEED THE SUPPORT OF CONGRESS TO FULFILL THEIR MISSION

Health centers request that this Committee and the Congress act to support our work in several specific ways. We have been, and will continue to fulfill our mission of providing high quality health services to the medically underserved at low cost. We will continue to bring needed health care professionals to underserved communities, and to work in partnership with local community to fulfill community needs and improve health outcomes of the people we serve in our areas. While we strongly recommend that the reauthorization of the federal health centers grant program under section 330 of the PHS Act proceed on schedule next year, there are a number of specific steps that this Committee and its Members can take this year to expand and improve access to quality health care for more uninsured Americans. Specifically, we need your help in the following areas:

Support increased resources to meet an ever-growing need for care. Health centers are doing their part to address this problem, but more must be done to serve the growing number of families who do not have access to health care services. More than 16.5 million uninsured individuals currently do not have access to a regular source of health care. We urge the Committee to actively support an expansion of the health centers program to at least double access to care for uninsured and underserved patients in the next five years. This can be achieved by increasing federal appropriations for the program by at least 15 percent per year through 2005—a small amount given the unmet needs for care. This plan would ensure access to quality health care for 20 million individuals by FY 2005, including 9 million uninsured persons.

Expeditiously reauthorize and strengthen the National Health Service Corps (NHSC). While the NHSC has proven successful in addressing health professional shortages in many areas, severe underfunding has undermined the program's ability to meet its primary goal. We strongly support action to reauthorize the NHSC at a level of at least $232 million this year. The NHSC also needs to be streamlined to work more effectively with safety net providers, including health centers, which share the goal of improving health care access in underserved areas. More NHSC providers should be placed at health centers to meet the health care needs of the uninsured and low-income individuals who reside in medically underserved areas.

Enact a permanent, stable, and fair Medicaid payment system for health centers. Since 1989, Congress has required health centers to be reimbursed for the costs of providing care to Medicaid and Medicare patients. Before cost-based reimbursement, health centers were forced to use Federal grant funds—originally intended to support care for the uninsured—to subsidize underpayments by the Medicaid program. Unfortunately, Congress in 1997 approved a phase-out of this vital payment protection, and while the 1999 Balanced Budget Refinement Act delayed the elimination of the Medicaid payment system for one year, it failed to establish a permanent solution for health centers' Medicaid funding problems. Without a secure, long-term Medicaid payment system, health centers will be forced to reduce services to the uninsured and many may be ultimately forced to close their doors. We urge the Committee to fully support the bipartisan Safety Net Preservation Act (S.1277), which would establish a Medicaid prospective payment system (PPS) for health centers. The PPS would provide a permanent and stable Medicaid payment system for health centers, ensuring that they are able to continue to care for low-income and uninsured individuals and that basic health services are sustained in local communities.

Support a more active role for health centers in enrolling children and other eligible persons in Medicaid and CHIP. As noted earlier, health centers have been frustrated over the past 10 years at the failure of States to comply with the outstationing requirement in Medicaid law, and at HCFA's failure to enforce compliance. We urge this Committee, which has clear jurisdiction over the health centers program, to convey its concern over these failures to both the Finance Committee and to HCFA, and to press for compliance with the current-law directives. For each of the 1.6 million uninsured children we care for who can be successfully enrolled in Medicaid or CHIP, we could serve one more uninsured person who does not qualify for any health insurance plan.

Assist and support the efforts of health centers to affiliate with each other and with other providers, and to fully participate in managed care systems. This Committee amended the health centers law in 1996 to make allowable the use of grant funds for costs related to the formation of integrated service networks and managed care plans, including such costs as the purchase of data and information systems, as well as legal, financial, and other technical assistance. In addition, the Committee established a new authority to allow HHS to issue loan guarantees to assist health centers in obtaining capital assistance, from private sources in the local community, for the costs of establishing information systems, improving and expand facilities, and making other infrastructure improvements, as well as the costs of meeting State licensure, risk reserve, and solvency requirements critical to network and plan formation and participation. However, the loan guarantee authority has encountered difficulties in meeting the States' solvency or risk reserve requirements, in two important ways: it does not permit the issuance of a single guarantee to a group of health centers, or to a managed care plan that is owned and operated by several health centers; and it is limited to the issuance of a loan guarantee, requiring a health center or centers to borrow capital and pay interest only to have the capital resources placed in a reserve account to meet a State's requirements.

Accordingly, we urge the Committee to revise the loan guarantee authority to allow HHS to issue solvency guarantees to a health center, a group of health centers, or a managed care plan owned and operated by one or more health centers, in order to meet a State's solvency requirements. This would result in substantial savings federal grant dollars, while assisting health centers to fully participate in Medicaid and other managed care arrangements.

We also urge the Committee to ask the HHS Inspector General to provide a 'safe harbor' for arrangements between health centers and other providers or suppliers of health care goods and services that will result in a documented savings of federal grant funds or will increase the availability or accessibility of health care services for health center patients. Alternatively, the Committee may wish to establish its own safe harbor for such arrangements under the PHS Act.

Comments on the New Community Access Program

Last year, Congress provided $25 million in funding for a new demonstration project, designed to encourage collaboration among health care providers and other community organizations to improve access to care for the growing number of Americans without health insurance. HHS is currently in the process of implementing this new effort, which it has named the Community Access Program (CAP). As members of the principal federal program directed at providing access to health care for uninsured and underserved Americans over the past 35 years, health centers would like to make some key points regarding this new program:

1. We welcome any effort that holds the promise of improving access to needed care for the uninsured and for other underserved populations, especially for efforts to help get other local providers of charity care to commit to providing needed services for our uninsured patients and others in an organized fashion. This is particularly important in these times when, as I have noted earlier, levels of charity care are falling in communities all across the country as managed care extends its hold.

2. Any resources provided for this new CAP program must not come at the expense of the levels of support needed to maintain and expand those programs that are already targeted at providing desperately-needed services and care to low income, largely uninsured populations—programs like the health centers, the National Health Service Corps, the Ryan White CARE Act programs, and others as well. This is particularly important since, under the model proposed by HHS, the new CAP program will not support the direct provision of health care services, except for filling limited service gaps in such areas as mental health or oral health.

3. Because true safety net providers—those, I repeat, with a legal obligation to provide care to persons who cannot afford to pay—are at the very core of health care delivery for the uninsured in local communities today, and have years of experience and the resulting expertise in organizing the provision of care for this population, then any local effort that is funded by the CAP program must clearly include local safety net providers, not just as participants but as core decision-makers and grant recipients. I should add that the HHS version of the CAP program is patterned after two similar initiatives undertaken in recent years by major philanthropic foundations (the Kellogg Foundation and the Robert Wood Johnson Foundation); and while these two new efforts are still in the earliest stages of operation, the experience of safety net providers with their locally-funded organizations has been mixed at best.

We intend to monitor closely the implementation of the new CAP program and to let members of both the Administration and the Congress know of the results. For the moment, I would say that we remain cautiously optimistic and hopeful that the new program will work, but with some serious concerns over the potential for confusion and duplication of effort when just the opposite is needed.

Thank you for this opportunity to present our views. We look forward to working with all the members of the Committee to improve and expand access to vital health care services for many more of America's uninsured and underserved.

[Additional material may be found in committee files.]

Prepared Statement of Mary Bufwack

Mr. Chairman and Members of the Subcommittee, my name is Mary Bufwack. I am the Chief Executive Officer of United Neighborhood Health Services, Inc., (UNHS) in Nashville, Tennessee. With me today in the audience is the Secretary of the UNHS Board, Wanda Hugger, who is also President of the James A. Cayce Homes Resident Association. We want to thank Senator Frist for the support and concern he has demonstrated for the uninsured and underserved and for the safety net providers that assure their access to health care.

UNHS had its beginnings in the early-1970's when mothers in the James A. Cayce Homes, a public housing development in Nashville, organized to bring pediatric care to their children whose only source of regular care was three miles away and across the river. From its first home in a 750 square foot public housing apartment staffed by volunteer residents and physicians serving the 500 children of the neighborhood, UNHS has grown to 6 centers providing accessible, affordable, quality, comprehensive primary care to over 10,000 clients, with 31,000 visits annually.

UNHS is heavily dependent on public programs to care for its patients. Fifty-two percent of those using UNHS services are uninsured, 42% are enrolled TennCare (Tennessee's version of Medicaid), 3% are enrolled in Medicare, and a scant 3% have private insurance. The overwhelming majority of UNHS patients are poor—86% live on incomes below 200% of the poverty level.

Today, twenty-five years after its founding and led by a client-based Board of Directors, UNHS is still pioneering ways to respond to the health care needs of the poor and underserved in Nashville. UNHS program developments have included: a rural clinic in an extremely underserved area 50 miles outside of Nashville; a perinatal program to address the problem of disproportionately high infant mortality; an affiliation with Meharry Medical College Family Practice Residency Program to provide community-based training to physicians and encourage service in underserved communities; two school-based centers one school-based center serving middle school students in a school where, before the center was established, a dead infant was found in a toilet and where 14 pregnancies per year were the norm, and the other school-based center serving pre-schoolers from a violence and drug-ridden community experiencing a 70% school drop-out rate; a center in the most isolated

public-housing development in Nashville with the highest rate of syphilis and new cases of HIV; an AmeriCorps program with thirty-five members providing home visits to new mothers in impoverished circumstances to avoid child abuse and neglect; a bilingual service for the 30,000 Spanish speakers who have moved to Nashville in the last four years; a diabetes initiative launched with a coalition of all safety-net providers; and opening on April 1, a women's health center and free standing birth center to assure access to gynecological and prenatal care.

The accomplishments of UNHS are a testament to the value of the health center grant program under section 330 of the Public Health Service Act, and we appreciate the support of this Committee for the program. We also are grateful for the work of the Bureau of Primary Health Care at HRSA in administering the health centers program, and also to the tenacity, perseverance and commitment of UNHS' other community safety net partners, clients and staff. But the climb is steep . and the obstacles great. To improve and strengthen the health centers program I want to tell you about some of those partners who have helped us when the going got rough and about some of those boulders that lies in our path and hinder our progress.

Throughout UNHS's 25-year history, the National Health Service Corps has been our most critical partner. Over 20 providers have provided more than 50 years of service to UNHS through this program. Every year, at least two of our 10 providers, and always one of our three physicians, is a scholar. When I first joined United Neighborhood 11 years ago, all three of the staff physicians were Corps Scholars. Today, of our three physicians, one is a scholar, one completed his obligation 2 years ago and one completed his obligation 15 years ago. I do not exaggerate when I say that without the National Health Service Corps UNHS would not be in existence today.

In the last 4 years I have also been denied additional positions because of the intense need among underserved areas. This leaves positions open for too long, enormously increases recruiting expenses and diminishes the services we can provide. More support is needed for this worthy program.

An additional problem faced is that changing HPSA (Health Professional Shortage Areas) designations jeopardize a health center's ability to qualify for placement of National Health Service Corp providers. While UNHS, with the state of Tennessee, has been able to successfully retain the HPSA designation of the areas in which its urban centers are located, our rural center lost its HPSA designation two years ago even though it is the only center serving the uninsured in a 50-mile radius. Matthew Walker Comprehensive Health Center, the first community health center in Nashville, lost its HPSA designation last year because of its geographic proximity to Meharry Medical College and the newly relocated Metropolitan General Public Hospital. If facilities serving the poor and uninsured were granted facility designation and automatically eligible to apply for National Health Service Corps support, such problems would be eliminated and more care could be provided for the uninsured.

I can also not advocate too strongly that the National Health Service Corps Program be as flexible and responsive to the needs of the local communities as possible in the types and mix of providers supported.

A major challenge that we face today is the rising numbers of uninsured. Uninsured in Tennessee you might say. Doesn't TennCare, Tennessee's Medicaid Managed Care Experiment, assure coverage to all uninsured Tennesseans? In 6 years, TennCare has made incredible strides, adding 500,000 uninsured to the 800,000 Medicaid recipients. But TennCare does not cover all of the uninsured in Tennessee.

With TennCare, the uninsured in Nashville were cut in half, from 80,000 to 40,000. But that achievement did not lessen the pressure on UNHS it only increased it because of the impact of TennCare on other providers of care for the uninsured. Unable to revise its methods of operation and with TennCare reimbursement so low, the public health department closed 5 neighborhood primary care sites and eliminated primary care, except for mandated public health services like immunization, TB testing and treatment, and STD testing and treatment, at its three major sites as well. Under the financial pressure of managed care, hospitals enacted policies that effectively reduced the use of the emergency rooms by the uninsured as well as TennCare recipients. Six years ago, before TennCare, the safety-net capacity for outpatient primary care services for Nashville's uninsured was estimated at 40,000. Today it is only 10,000—the capacity of UNHS, Matthew Walker and a Health Department homeless clinic. As traditional providers of primary care for the uninsured leave the playing field and others restrict their charity care, community health centers must expand services to the underserved just to maintain the status quo.

And there is a growth in the uninsured population of Nashville that is now pushing the numbers above 40,000. These sources include substantial immigration into

Nashville, attracted by jobs without health insurance. And many who had insurance are losing it. In response to the rising cost of health insurance, many employers are dropping insurance, reducing insurance coverage to only catastrophic care or requiring employees to share such a proportion of the insurance that it has become unaffordable.

Over the last three years, UNHS has maximized its own resources, and coordinating with community partners including Matthew Walker, Metro General Hospital, Meharry Medical College, Vanderbilt Nursing and Medical School, and the Metro Health Department, and has increased its services by nearly one-third. But communities cannot meet these needs alone. As the Community Access Program is promoted to encourage coordination among safety-net providers to maximize resources, primary care, the central component of any integrated system of care, must receive additional resources to expand.

Lastly, I cannot leave here today, without addressing the problems for Tennessee's community health centers caused by the elimination under TennCare of "reasonable cost-based reimbursement". While Medicaid is not within the jurisdiction of this committee, it is a fact that mechanisms for Medicaid reimbursement have a profound impact on how the resources authorized by this committee are used. Half of our clients in Nashville are the uninsured and the other half are those TennCare recipients lacking access to other providers. Just as we at the local level must coordinate our efforts and maximize our resources, so must legislation at the Federal level be coordinated to assure that this safety net is not supported by one hand and then torn apart by the other.

Over 10 years ago, Congress wisely saw that health center grant funds under the jurisdiction of this Committee should go to the service of the uninsured and NOT to subsidize low state Medicaid payments. For the limited number of years that UNHS had "reasonable cost-based reimbursement, "our federal Public Health Service Act grant funds were freed up and did not subsidize Medicaid underpayments. This allowed UNHS to add providers to care for more uninsured and to enhance our services with two case managers, a licensed clinical social worker, so needed with the mental health needs of our clients, and a nutritionist to support our clients in their efforts to change their diets to control the devastating consequences of hypertension and diabetes.

January 1, 1994, when the entire state of Tennessee placed all its Medicaid recipients in a program of managed care, was a day that will live in our memories. As with Y2K, we never felt quite prepared and there were many predictions of disaster.

The 17 Tennessee community health centers have 63 sites, serving 200,000 clients. We jointly serve 55,000 uninsured and 90,000 TennCare recipients in underserved rural and urban areas. We, non-profits with no financial reserves, completely dependant upon federal funds and Medicaid payments, are the unintended and unwilling experimental subjects answering the question: Can community health centers survive in a market driven managed care system for Medicaid with no special consideration of their safety-net status? Yes we can survive. UNHS laid off all these new allied health providers and eliminated their services. We also made the difficult decision to close the practice of our one dentist in order to maintain the expanded medical services that we considered our core service. Yes we can survive. Living hand-to-mouth and payroll to payroll we are keeping our doors open. Yes, we can survive. Last year UNHS used at least $300,000 of combined federal funds and local contributions, 10% of our total budget, to subsidize TennCare.

And now we are further challenged by the current crisis of TennCare and financing in Tennessee, which includes managed care organizations crumbling in debt and unable to pay providers, and physicians and hospitals leaving the TennCare program and throwing their patients to those who are left to serve as best they can. I need not tell you that it is to our door, the accessible service, to which these abandoned patients first turn.

We need your coordinated help in assuring that the Medicaid payment system for health centers is fair and permanent. Our experience demonstrates the negative effects of phasing out "reasonable cost-based reimbursement". With your assistance, health centers in other states and those they serve can be spared the hardship endured by centers in Tennessee. Your involvement in this issue is essential if you want to assure that the Public Health Service Act funds, intended for the uninsured, are truly invested in addressing their needs and growing numbers.

Our commitment to establish fair and stable payment from Medicaid is fueled by our knowledge of what UNHS can do with that $300,000. It would support another 1,500 patients and 4,000 medical visits. It means a 30% increase in the uninsured UNHS can serve. It means services to those who would go without: a homeless man whose war experiences left him ravaged, a pregnant woman legally resident in the U.S. and unable to speak English, a songwriter and musician, a factory worker mak-

ing minimum wage, a child who is two and is not speaking in ways we can understand because of hearing problems, a couple who are starting a restaurant business, and an elderly person who cannot afford their medications. Don't let them down.

In summary, Mr. Chairman, UNHS and its patients appreciate the support you and this Subcommittee have given UNHS and health centers around the country. There are three things you can do to help us in our work to care for the uninsured and underserved people of this nation:

First, substantially increase resources for the health centers program. Access to care for the uninsured and underserved can be doubled in five years by increasing appropriations for the grant program by at least 15% in each of the next 5 years allowing access to care at health centers for 20 million individuals, including 9 million uninsured.

Second, reauthorize and strengthen the National Health Service Corps this year. Increase the authorization to $232 million and provide automatic facility designations for health centers. This will help us bring health professionals to where they are most needed.

Third, please work with your colleagues on the Finance Committee to provide consistent and coordinated support for the health centers program by enacting S.1277, the Safety Net Preservation Act. If health centers are to continue to effectively serve the growing numbers of uninsured, they need a fair, stable Medicaid payment system that will make sure that Medicaid underpayments are not subsidized by the grant funds that this Committee authorizes for care for the uninsured.

Thank you for the opportunity to appear before the Subcommittee today.

Prepared Statement of Robert L. Taube

Thank you for inviting me to testify today. My name is Robert L. Taube, and I am the Executive Director of the Boston Health Care for the Homeless Program. I am also a member of the Board of Directors of the National Health Care for the Homeless Council (National Council), on whose behalf I am testifying today.

The National Council is a membership organization representing agencies that receive funds through the federal Health Care for the Homeless (HCH) Program.

Before I begin, I want to extend on behalf of the homeless community our deep appreciation to Chairman Frist, Senator Kennedy, and other Committee members for ensuring that last year's reauthorization legislation for the Substance Abuse and Mental Health Services Administration included renewals of two targeted homeless addiction and mental health services programs—PATH and GBHI. These programs are critical components to the federal response to homelessness. Thank you for your leadership.

As I begin, it is imperative that I express the National Council's profound regret that our nation continues to fail to guarantee access to health care as a fundamental right for every American. Ultimately, Americans' health care access challenges, including those facing persons without stable housing, must be redressed through a universal health care system.

HEALTH AND HOMELESSNESS

Homelessness causes poor health, exacerbates existing illness, and seriously complicates treatment for those experiencing this tragic life condition. The adverse health status of persons experiencing residential instability, and the consequent restrictions to comprehensive health care associated with homelessness, are reflected in the extremely high rates of both chronic and acute health problems among persons experiencing homelessness.

Homeless persons' access to appropriate treatment and care is hindered dramatically by a lack of health insurance coverage. National data gathered by the HCH program reveals that 74 percent of HCH patients have no source of health insurance. It is clear, then that the rate of uninsurance among homeless persons is disproportionately high when compared to the uninsurance rate of the general population.

Among the reasons for the low rate of health insurance coverage among persons experiencing homelessness: many homeless persons with employment income work for employers that do not offer or do not pay for their workers' health insurance; and, many homeless persons, particularly non-disabled adults without accompanying children, do not qualify for public health insurance.

For persons without stable housing, health care inaccessibility is not solely dependent on their uninsured status. Homeless persons also encounter barriers to accessing and utilizing the health care safety net system. Inaccessible public transportation, inflexible service hours, prohibitive fees, negative provider attitudes, system

insufficiencies, and residency and documentation requirements are among the obstacles.

HEALTH CARE FOR THE HOMELESS PROGRAM

Recognizing that those experiencing homelessness frequently lacked access to health care and that neither the mainstream health care insurance or safety net systems were responding to these unmet needs, Congress established a targeted health program specifically for them—Health Care for the Homeless. First established in 1987 and currently authorized in the Consolidated Health Centers Act of 1996, the HCH program makes grants through a competitive award process to community-based public or nonprofit entities (including community health centers, public health departments, private nonprofit organizations, and hospitals) to assist them in planning and delivering high-quality, accessible health care to homeless persons. HCH projects provide primary health, mental health, addiction, and social services with intensive outreach and case management to link clients with appropriate services. HCH service delivery sites vary by project, but include fixed-site health clinics, homeless shelters and soup kitchens, mobile medical units, and street outreach teams. HCH projects served over 430,000 patients in 1998. The HCH program currently funds 130 grantees in 48 states, the District of Columbia, and Puerto Rico. My project, the Boston Health Care for the Homeless Program, is one of the grantees.

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

The Boston Health Care for the Homeless Program is a private, nonprofit corporation that assists our local health care safety net system in addressing the unique needs and life circumstances of persons who struggle with the health and social consequences of persistent poverty without the security of safe and affordable housing. We provide comprehensive health care services to homeless people in the greater Boston area—serving over 7,000 men, women, children, and youth annually. We provide a comprehensive array of primary care, oral health, mental health, and addiction services. In addition to the health and enabling services we are required by law to provide, the Boston project—like many other HCH projects—provides a number of additional services. We offer an array of comprehensive oral health services to children and adults, as well as HIV primary care and case management services. The most noteworthy additional service we have developed is an exemplary 90 bed medical recuperative care program. This activity addresses the needs of homeless people who are too sick to remain in shelters or on the street but do not require acute hospital level care.

The Boston HCH program has a particularly extensive service network, operating out of three hospital-based clinics and over fifty community-based sites spanning homeless shelters, soup kitchens, and detoxification programs. We also provide services to unsheltered people on the streets and under bridges, as well as at a local racetrack where otherwise homeless and itinerant workers reside in barns during the racing season.

Nationally, the HCH program is highly successful and we have evidence of these positive outcomes in our own project. Take for example the following illustration: In winter 1998, Boston witnessed 16 deaths of homeless people on the streets. The community's concern grew with the mounting death toll. Acting in its bridging capacity between medicine and public health, our program undertook a case-by-case mortality review of the circumstances of each death. Finding patterns enabled us to identify those currently at greatest risk of dying on the streets, and enabled us to propose and coordinate a response supported by hospitals, detoxification programs, shelter outreach teams, and our health care practitioners. With funds from the city and state, we led a coordinated effort to respond to those at highest risk of death. This winter, with this response in place, only four people have died on the streets.

While deaths on the streets are dramatic and highly visible, they are only the tip of the iceberg in terms of the health risks inherent to homelessness. The management of chronic diseases, complicated by the uncertainties of life on the streets and in the shelters, has been a major focus of our and other HCH projects. For example, diabetes is a chronic illness associated with devastating morbidity, including heart attacks, blindness, loss of limbs, and kidney failure. These complications can be delayed or avoided with effective primary care that helps control blood sugar levels. A nutritious diet and regular exercise are the mainstays of diabetes treatment, both of which are virtually impossible for homeless persons. Insulin, which needs to be injected as frequently as four times a day, is a medication that is often inaccessible to those in shelters. Adherence to acceptable standards of care for diabetes requires

significant adjustment by health care providers, and HCH projects have much expertise and experience to offer mainstream health care providers in contact with the homeless population. Our own project reviewed a random selection of charts of homeless adults with diabetes, and found that 80 percent of the medical records met between six and nine of 11 standards that were rigorously chosen from available guidelines B exceeding the benchmarks of many mainstream health care providers and demonstrating that HCH programs are an invaluable adjunct in efforts to improve health care outcomes for homeless persons.

I want to take a moment to acknowledge the importance of the National Health Service Corps program to our project and others. The Boston project was qualified as a NHSC scholarship and loan repayment site four years ago. Since that time we have employed four internists with support from the NHSC. Two have remained on our staff after their scholarship commitments ended and continue to make important contributions to our overall efforts. In addition, through the NHSC, we have been able to provide loan repayment benefits to three outstanding nurse practitioners. The loan repayment program has made it possible to keep them with us despite repayment burdens that would otherwise have forced them to find higher paying in the private sector.

CHALLENGES FACING HCH PROJECTS

The fundamental challenge facing all HCH projectsCas well as all health centers and other health care safety net providersCis one of insufficient resources to sustain and expand services to persons with limited or no means to pay for health care. This failure to appropriately invest in the nation's health care safety net prevents HCH projects from fully responding to the following dynamics among and needs of persons without stable housing:

Increasing Homelessness—As an increasing number of individuals and families fall below federal poverty guidelines and find themselves living with friends, relatives, in shelters and the streets, more people are seeking services from HCH projects. Among the new patients of HCH services are families with children exiting the welfare system, persons with addiction who have been denied access to Medicaid, Aworking poor individuals without housing or health insurance, undocumented immigrants, emancipated and unaccompanied youth, and veterans unable to obtain Department of Veterans Affairs health services. HCH projects do not receive sufficient funds to adequately serve their current caseloads, much less address the increased demand for services from these emerging homeless subpopulations.

Untreated Addiction and Mental Illness—HCH projects report that addictions and mental illnesses are among the most prevalent diagnoses of their patients. Regrettably, HCH projects do not receive sufficient funds to offer more than an elemental level of addiction and mental health care.

Lack of Supervised Medical Care for Persons in Recuperation—The unavailability of appropriate accommodations for those requiring supervised medical care, but not ill enough to remain hospitalized, makes it difficult for individuals to recover from illness and resolve their homelessness. HCH projects do not receive sufficient funding to develop or expand recuperative care arrangements for patients in desperate need of such services.

Financial Distress of HCH Projects—Many HCH projects report decreasing revenues, especially from Medicaid. The enrollment of Medicaid beneficiaries in managed care organizations has resulted in a dramatic decrease not in the number of Medicaid beneficiaries served by HCH providers, but in the reimbursements received from Medicaid. Additionally, many homeless persons who are enrolled in Medicaid receive unreimbursed services from HCH projects because their in-plan providers are not accessible or do not offer appropriate services. The phase-out of Medicaid cost-based reimbursement for health centers has also decreased revenues during a period in which actual costs continue to rise.

POLICY RECOMMENDATIONS REGARDING HCH PROGRAM

The National Health Care for the Homeless Council recommends that Congress take the following actions to respond to the challenges facing HCH projects enumerated above:

. Reauthorize the Health Care for the Homeless program and other health center programs. At a minimum, the reauthorization should: retain HCH as a distinct program within the consolidated health center account; ensure appropriate allocation of funds among all health center programs within the consolidated health center account; and include an authorization amount of at least a 100 percent above the FY 2000 appropriation level.

We urge the Committee to utilize the year remaining in the account's authorization to conduct a deliberative reauthorization process. The National Council will provide Congress additional recommendations regarding health centers reauthorization in the coming months.

2. Appropriate $129 million for the Health Care for the Homeless program in FY 2001 as part of an overall $1.5 billion appropriation for the consolidated health center account.

3. Appropriate $75 million for the Projects for Assistance in Transition from Homelessness (PATH) program in FY 2001 and $100 million for the Grants for the Benefit of Homeless Individuals (GBHI) program in FY 2001. We express our deep gratitude to Senators Susan Collins (R-ME) and Jack Reed (D-RI) for inviting their colleagues to join them in requesting Chairman Specter to appropriate at least $50 million for each program. We hope that all members of the HELP Committee will join their sign-on letter.

4. Reauthorize the National Health Service Corps. At a minimum, the reauthorization should: include a multi-year authorization level of at least $232 million annual; and automatically designate all federally-qualified health centers as Health Professional Shortage Area facilities for placement of Corps personnel.

5. Enact the Safety Net Preservation Act (S. 1277/H.R. 2341), which establishes a prospective payment system for reimbursing federally-qualified health centers, including HCH projects, for their services to Medicaid beneficiaries.

COLLABORATION AMONG HEALTH CARE SAFETY NET PROVIDERS

As the principal health care safety net providers to persons with the most complex and interrelated medical and social conditions possible, HCH projects have had to foster collaboration among health, housing, and support service providers in their communities.

For example, BHCHP is one of ten affiliated health centers that participate with Boston Medical Center as a member of the Boston HealthNet, an integrated service delivery network serving many of Boston's poorest residents. In addition, we operate in close affiliation with the city public health department, addressing preventable illness and infectious disease within the shelter community, and infant mortality among the city's most vulnerable families. We work in close collaboration with state agencies including the Massachusetts Department of Public Health and the Massachusetts Department of Transitional Assistance. We work closely with the Massachusetts League of Community Health Centers and with the city's "continuum of care" coalition convened by the Mayor's Emergency Shelter Commission as part of the HUD McKinney program. Through these affiliations and linkages we address issues from street deaths in the winter to rubella outbreaks in family shelters to the housing needs of mentally ill adults.

Despite evidence of the criticality of collaboration in providing effective care to vulnerable and underserved populations, we have reservations about the recommendation by the Clinton Administration to authorize a new federal grant program, the Community Access Program, solely for this purpose. Fundamentally, we believe that limited federal safety net health care resources should be directed to the support of services rather than to interactive functions. Collaboration and linkages are inherently uneventful processes if there are not sufficient services available to meet the needs of those for whom the collaborative interactions are occurring. Also, we note that current health care safety net statutes, including the consolidated health center law, already require grantees to collaborate with their health care safety net partners as a condition of receiving federal funds. Accordingly, new federal funds should be invested in current federal programs to enable grantees to meet their statutory obligations.

In a less competitive fiscal environment, the National Council would welcome the designation of new funds for both services expansion and in the networking and infrastructure development necessary to effect collaboration. Reluctantly, given the "zero sum" budget game in which Congress and the Administration are currently engaged, we must state our preference that new appropriations for the health care safety net be directed to health services expansion.

Thank you for the opportunity to testify. I am happy to answer any questions you may have.

PREPARED STATEMENT OF LARRY S. GAGE

Good morning. I am very pleased to have this opportunity to address the Subcommittee on behalf of the National Association of Public Hospitals & Health Systems (NAPH) to discuss the situation of America's safety net hospitals and health systems. I am especially pleased to testify in support of an exciting new initiative

of tremendous importance to such providers and the uninsured patients they serve. Although in its infancy, the Community Access Program has already demonstrated the power of an idea. The overwhelming response that the Health Resources and Services Administration (HRSA) has received from its initial program announcement speaks volumes about the need for an initiative that seeks to transform a fragmented system of safety net providers into a coherent and integrated whole. It is with great enthusiasm that I am here to ask for your support for this program.

Before I do so, however, I would like very briefly to describe for those Senators who may not be familiar with NAPH who we are and the role our members play in the safety net health system in our country today. I also want to share with you the encouraging results of a 1999 NAPH-sponsored poll indicating near-unanimous public support for protecting and strengthening safety net providers. The core of my testimony will focus on the importance of the Community Access Program. Finally, I will also take this opportunity to discuss other current proposals to address the problem of the uninsured.

Safety Net Hospitals are an Essential Component of the Health Care System for the Uninsured

As hospitals, NAPH members receive federal support primarily through the Medicaid and Medicare programs, although most of our members also participate in many of the categorical programs over which this committee has jurisdiction. Unlike other organizations represented on this panel, however, public hospitals have no dedicated federal program authorizing their existence so we do not come before you on a regular basis for reauthorization. For that reason, we may not be as familiar to you as we are to your colleagues on the Finance Committee. I would therefore like to take a few minutes to describe our members to you.

NAPH is comprised of about 100 of the nation's largest urban and metropolitan area safety net hospitals and health systems. These institutions are committed to providing health care services to all individuals without regard to ability to pay. In other words, over 80 percent of NAPH member inpatient services are provided to Medicaid and Medicare patients or the uninsured. 28 percent of inpatient services at NAPH hospitals (as measured by the proportion of gross charges) are provided to individuals without health insurance. Another 33 percent are provided to Medicaid patients, and 21 percent to Medicare beneficiaries.

When many people think of safety net hospitals, they think of large acute care centers. Our members certainly do provide substantial secondary and tertiary care, including highly costly specialized care that is relied on by the entire community: Level I trauma care, neonatal intensive care, burn units, emergency psychiatric care, and other specialized services. In 1997, the most recent year for which we have data, our hospitals had on average 405 staffed beds and provided over 16,600 discharges and 105,000 inpatient days per hospital. Demand for inpatient care at NAPH hospitals is very high by industry standards, with an average occupancy rate of 71 percent as compared to 62 percent for all hospitals.

But in addition to inpatient care, NAPH members also provide a substantial volume of outpatient care, including primary and preventive care through community-based neighborhood clinics. In 1997 just 77 NAPH members provided 25 million outpatient visits, for an average of almost 332,000 visits per hospital. Only 58 percent of these visits were reimbursed; 42 percent were provided to the uninsured. Medicaid and Medicare reimbursement for outpatient services is, however, typically less than the cost of such care, so that 86 percent of outpatient care was either unreimbursed or reimbursed below cost.

Overall, NAPH members shoulder a hefty burden of uncompensated care, and the weight of the burden is on the rise. In 1997, 29 percent of total costs at NAPH hospitals were uncompensated, up from 23 percent in 1993. This rising level can be attributed to a variety of factors: the growing number of individuals without health insurance; increasing competition for paying patients, including Medicaid patients; the drop in Medicaid enrollment due to welfare reform; and restrictions in coverage for legal immigrants, to name a few.

So how do NAPH hospitals finance this level of uncompensated care? The largest source of support—47 percent—comes from local government subsidies for indigent care. Medicaid Disproportionate Share Hospital (DSH) funds are also extremely important, covering 22 percent of uncompensated costs. Another 8 percent is paid for through Medicare DSH payments, 7 percent through Medicare IME, and 4 percent through cost shifting from third-party payers. The remaining 12 percent is from other miscellaneous sources, for example, many NAPH members also receive grants under various Public Health Service Act programs under the jurisdiction of this Subcommittee, such as Ryan White CARE Act programs, block grants for maternal

and child health and the homeless, and substance abuse and mental health services. Many also operate health centers and other programs that qualify as FQHCs.

In sum, NAPH hospitals and health systems are a very significant source of care for our nation's uninsured and low-income populations. Together with the community health centers, rural health clinics, public health departments and other essential providers, they constitute a de facto national health care system for the uninsured.

Public Support for Safety Net Providers is Overwhelming

Last May, NAPH conducted a poll of 1000 Americans in urban and suburban households to gauge their support for safety net providers. Even we were surprised by the clarity of the results. We found an overwhelming endorsement for safety net providers and the work that they do, with the support cutting across all lines of age, gender, income level and political affiliation.

A full 96 percent of respondents said that it is important that there be safety net hospitals and clinics in their community to care for the uninsured, with 85 percent specifying that it is very important. 72 percent responded that more money should be spent on safety net hospitals, with a majority of these individuals indicating that they were personally willing to contribute more money to care for the uninsured. Over half of the respondents said that they are currently uninsured or have been so at some point in the past. One-third of the currently insured thought that they or a family member may become uninsured in the next five years.

Clearly, personal experience and fear of being without health insurance drives much of the support for the safety net. People realize that anybody can become uninsured at any time, and that it is important that a safety net system of care be firmly in place to assist those in need. This public support is relevant as you consider the various safety net programs under discussion here today.

The Community Access Program Will Help Integrate Care for the Uninsured

NAPH has long believed that the solution to the problem of the uninsured lies in extending health care coverage to all. That is a goal to which we continue to be committed. We look forward to working with Congress, and with members of this Committee in particular, in taking steps towards achieving that goal.

As a complement to expanding coverage, however, NAPH also believes that we should address the needs of safety net providers that care for those individuals who remain uninsured. (In fact, we believe that even under a system of Auniversal coverage there would still need to be a safety net for those individuals and services that would inevitably fall through the cracks.) The federal government currently invests billions of dollars in support of the safety net through a variety of programs—Medicaid and Medicare Disproportionate Share Hospitals payments, Section 330 health center funding, Ryan White, family planning programs and others. Each of these federal programs, however, is targeted on a particular type of provider. There is no federal funding source that cuts across these program lines and encourages the different types of providers to work together. As a result, from the perspective of an uninsured individual, the care that he or she receives is often fragmented and inefficient.

The Community Access Program, which Congress launched last year as a demonstration program, seeks to redress this gap. It provides competitive grants to consortia of different types of safety net providers within a community to encourage them to collaborate in providing care to the uninsured. The idea is not to impose a federal Aone-size-fits-all

solution on the entire country, but rather to let each community assess its own particularized needs and develop its own particularized solutions with a minimum of federal mandates. The primary federal requirements are that the grants be to consortia of providers rather than individual providers, that the projects enhance care for the uninsured, and that the recipients demonstrate an historical commitment to serving the uninsured population. Locally tailored solutions will be developed to address local needs.

The program is modeled after much smaller grant programs run by the Kellogg Foundation and the Robert Wood Johnson Foundation. Recipients of those grants provide us with a glimpse of the types of innovative projects that could be funded through the Community Access Program. For example, NAPH member Denver Health is a recipient of a Kellogg Community Voices grant. It is using the funding to strengthen the local safety net consisting of community and school-based primary care sites, the county public health department, the region's top trauma center, the city's 911 EMS system and a poison center. They have identified three critical barriers to care: inadequate and fragmented outreach, awkward enrollment and poor case management, and are using the grant money to address each. For example,

they have developed a concentrated case management program targeted on patients whose main diagnosis is accompanied by a diagnosis of substance abuse or chronic mental illness. These patients tend to be far more likely than others to require multiple hospitalizations in a given year. Through improved coordinated care and preventive services Denver Health expects to significantly reduce the $10 million it spends annually on this population. Already, a pilot group of 12 patients have reduced hospital days from 257 to 64 in just seven months.

Other potential uses include: Developing shared information systems that will allow safety net providers to better coordinate patient care; Creating a formal integrated network of providers to coordinate care for the uninsured; Sharing clinical systems, including expensive technology, to avoid duplicative expenditures and make more efficient use of existing funding sources; and Implementing computerized clinical decision-making tools to be shared among a consortium of providers.

The potential variations are as numerous as the number of communities in need.

We also see the potential for the investment of federal dollars to leverage even greater sums in additional public and private dollars, through public-private partnerships. The Denver example I mentioned earlier is a good case in point. Denver Health took the $2.5 million in Kellogg funding and used it to leverage an additional $2.5 million from a local foundation and possibly another $1 million from the city for a total of $6 million in funding. Clearly participants in any consortia would be dedicating significant financial and in-kind services to their projects as well. In the end, the impact from a relatively small amount of federal funding could potentially be much greater than a dollar-for-dollar correlation would suggest.

Last year, Congress launched the Community Access Program through a $25 million appropriation for a demonstration project called Access to Health Care for the Uninsured. The idea, originally included in the Administration's FY 2000 budget request, was to have an initial year of seed funding at the $25 million level, to be followed by a bigger investment of $1 billion over five years. Clearly, an investment at that level will require authorizing legislation, which we are looking to this committee to help us get enacted. The program would not be a permanent fixture in the Public Health Service Act; it would sunset after five years.

The higher funding level in years two through five is not intended to change the qualitative nature of the program. It would merely allow more communities to receive grants. This year, the $25 million will cover grants to about 20 communities. If fully funded in future years, 100 or more communities could receive funding.

And clearly the need is out there. HRSA is to be highly commended for the speed and efficiency with which it has launched this program. It issued a Federal Register notice in February announcing the availability of grants, and the response has been beyond all expectations, even for those of us who are the biggest champions of the program. We understand that HRSA has received 1800 requests for applications to date—and this for a mere 20 initial grants! Requests have poured in from every state in the union, including the District of Columbia and Puerto Rico. NAPH can supply any member of this committee with a list of interested applicants from your own state if you would find it helpful. Over the last two weeks, HRSA held a series of six regional pre-application workshops across the country, all of which attracted standing room only crowds. NAPH participated in all of the workshops, and I myself attended the workshop last week in Los Angeles. I can only describe the atmosphere in that room to you as Aelectric.

There was an energy and enthusiasm that I have not seen for a federal program in years. As I spoke with people from all over the Southwest about their ideas for projects even I, who has long endorsed this idea, was impressed with the creativity and the potential to make a real difference in the quality of care for the uninsured. As I said, clearly the need and the demand for this kind of program is out there.

You all should have received a letter supporting the Community Access Program from a coalition of groups that NAPH has organized representing safety net providers, local governments and others—about 15 groups in all. I have attached a copy to my testimony. As we have begun talking to members of this committee and others in Congress about this idea the response has been overwhelmingly supportive, and we thank you for that support. Now, we ask that you consider establishing the Community Access Program as a fully authorized program, so that we can encourage even more communities to begin down the path of providing truly quality care for our nation's uninsured.

Congress Can Also Take Other Steps to Address the Needs of the Uninsured

My main purpose in addressing you today is to ask for your support for the Community Access Program. But I do not want to lose the opportunity to mention, however briefly, other proposals that NAPH believes must be part and parcel of any solution to the problem of the 44 million uninsured Americans. These include: Expan-

sion of the children's health insurance program to cover parents, pregnant women and/or other populations; Expanded outreach and enrollment initiatives to ensure that those eligible for existing programs are actually covered; and Stabilization of the Medicare program without impacting current eligibility or guaranteed benefits, and an expansion to cover prescription drugs and buy-in opportunities for certain populations (such as early retirees).

In addition, we believe that there is a need for a renewed commitment from the federal government for direct support for services provided by safety net providers (which the Community Access Program would offer in only a very limited way). In particular, the Medicaid Disproportionate Share Hospital program, which as I mentioned earlier covers nearly one-quarter of the uncompensated care provided by NAPH members, is scheduled for dramatic cuts over the next three years. By 2002, the program will be shrunk by 38 percent. Safety net hospitals simply cannot absorb cuts of that magnitude, at a time when the number of uninsured and the amount of uncompensated care is rising so quickly. We therefore support measures in both the House and Senate that would eliminate the final two years of the scheduled DSH cuts. Bipartisan legislation has already been introduced in the House to accomplish this goal. Even though we understand that Medicaid is outside of this committee's jurisdiction, we ask for your help and support for this legislation in the months ahead.

In the same vein, we endorse efforts to expand funding for health centers through the 330 program so that services can be doubled over the next five years. Like safety net hospitals, community health centers, migrant health centers and healthcare for the homeless programs have been and always will be there to serve populations whom other providers scorn. They are an essential and integral part of the safety net healthcare system in this country, and the work that they do should be supported and expanded so that they can reach even more individuals in need.

Once again, I thank you for granting me the opportunity to speak with you this morning. I would be happy to address any questions you may have.

Statement of the American Academy of Family Physicians

This statement regarding the role of safety net providers for the uninsured and the need for reauthorization of the National Health Service Corps, in particular, is submitted to the Public Health Subcommittee of the Health, Education, Labor, and Pensions Committee on behalf of the 89,400 member of the American Academy of Family Physicians.

FAMILY PHYSICIANS ARE IMPORTANT SAFETY NET PROVIDERS

Patients make 200 million office visits to family physicians each year—79 million more than any other specialty. In fact, one out of every four office visits in America is to a family physician. Family physicians see one out of every five children to provide their health care, and one out of every four women for their health care. Of these office visits, 6% are delivered without any charge, a rate at least twice as high of any other primary care specialty. Consequently, family physicians are important linchpins within the health care system for uninsured individuals because of their broad scope of practice and focus on primary care.

Family physicians are important to all Americans but are essential to rural dwellers. According to analysis performed by the Center for Policy Studies in Family Practice and Primary Care, of the 2,298 rural counties in the U.S. that do not qualify as Health Professional Shortage Areas (HPSA), or only partially qualify, 58% would achieve the ignominious distinction of full qualification if their practicing family physicians were to move away. Similarly, the withdrawal of other primary care specialties practicing in rural areas would change HPSA status for the worse for an additional 3% of counties. Family physicians' importance as part of the primary care safety net continues across the spectrum of HPSA designations, regardless of population size. In HPSA counties with urban populations of more than 2.5 million, 70% of counties that do not qualify or only partially qualify as underserved would be designated as underserved if their practicing family physicians left the area. By comparison, only 5% of these same areas would be declared underserved if other primary care specialties left their current practice areas.

Family physicians are also essential safety net providers for communities that would otherwise be without access to regular, coordinated medical care. For example, they provide significant staff for Community and Migrant Health Centers. Over 83% of family physicians participate in Medicare and Medicaid. The National Health Service Corps (NHSC), in particular, provide the necessary infrastructure to place family physicians in underserved areas. The Academy supports the reauthorization of the NHSC this year.

ACADEMY SUPPORT FOR THE REAUTHORIZATION OF THE NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps was created in 1970 to place primary care physicians and dentists in areas of greatest need of access to health care—typically economically disadvantaged urban and rural areas. The Corps places primary care physicians, dentists, and non physician providers (nurse-midwives, nurse practitioners, and physician assistants) in communities through a combination of scholarships and loan repayment programs. Scholarships are awarded on a year to year basis in return for a service obligation of at least two years. Loan repayment is offered to selected clinicians who have been hired by an independent entity in an underserved community as an incentive to recruit and retain adequate health care personnel.

The Bureau for Primary Care estimates that there is an unmet need for 20,000 primary medical, oral, and mental health clinicians. In 1999, the Corps had 2,349 clinicians serving in underserved areas of the U.S. through an appropriation of $115 million. At current levels, the Corps is only equipped to meet 12% of the health care access needs in the nation's underserved areas.

The Corps' authorization expires this year and it is vital that this program be reauthorized so that it can continue to offer access to vital health care services to the nation's most underserved populations. The Academy supports an increased authorization level as a part of any reauthorization proposal. Currently, no reauthorization legislation has been introduced in either the House or the Senate although action is expected this year.

ACADEMY SUPPORT FOR EXCLUDING NHSC SCHOLARSHIP FROM TAXATION

The Corps' vital work is currently weakened by the Internal Revenue Service's interpretation that medical school tuition and fees are taxable income for NHSC scholars. After deducting taxes for tuition and fees from the medical student's stipend, very little is left to live on. This is a deterrent for participation in the scholarship program. This diversion of scare resources from the program needs to be ended so those tax dollars can continue to secure medical care in some of the most remote and economically depressed areas of the nation.

The Academy supports four bills that exclude from gross income, for purposes of taxation, payments made by the Corps for tuition and fees to medical schools for indebted scholars. The four pending bills that would exclude Corps scholarships from taxable income are: H.R. 324, introduced by Sander Levin (D-MI), H.R. 1414, introduced by Nancy Johnson (R-CT), H.R. 3120, introduced by Spencer Bachus (R-AL) and S. 288, introduced by Sen. Jim Jeffords (R-VT).

The Academy looks forward to working with Members of the Health, Education, Labor and Pensions Committee to pass a strong reauthorization bill for the National Health Service Corps this year.

STATEMENT OF THE MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS

Community Health Centers as Economic Engines:

An Overview of their Impact on Massachusetts Communities and Families

Origins of Community Health Centers

Jack Geiger, M.D., co-founder of the nation's first two community health centers (CHCs), observed that "...the poor get sicker, and the sick get poorer." This understanding -- that poverty-causing conditions must change before lasting improvements in health can be sustained -- served as the organizing philosophy held by the pioneers of community health center development in the mid-1960s.

As community-owned institutions, health centers were originally intended to serve the health care needs of their communities and to act as vehicles for local community development and empowerment. The early national pilot programs in Boston at Columbia Point and in the Mississippi Delta at Mound Bayou included community economic development and job creation as integral components of the mission of these centers. As word of these spread, residents of other communities began door-to-door organizing efforts advocating for the establishment of neighborhood-based, community-oriented health care practices in their neighborhoods. These centers would employ community residents and remain accountable to the community.

In keeping with their community development roots, federally-funded health centers were first established under the Office of Economic Opportunity (OEO), not under the Department of Health, Education, and Welfare (HEW). HEW, which had primary responsibility for health care legislation and the creation of new health care institutions, was busy at the time establishing the Medicaid and Medicare programs. As a creation of OEO, CHCs joined Community Action Programs (CAPs) and Community Economic Development Corporations (CDCs) as part of the "War on Poverty" arsenal, each targeted to intervene at a key point in the cycle of ill health, unemployment, substandard housing, limited educational opportunity and poverty that overwhelms poor communities.

CHCs Current Economic Benefits: Stabilization and Stimulation

Thirty years after the first health centers were founded, community health centers are stable community assets that:

- assess health risk and contribute to community-oriented public health;
- provide accessible community-based personal health care; and
- operate as economic development engines within low-income communities.

CHCs are governed by neighborhood boards, the members of which in many instances also provide leadership for other community projects. In addition, CHCs employ neighborhood residents in over 50 percent of their nonprofessional health care and support staff roles. Community health center staff and leadership provide role models and assistance to community residents in defining and pursuing their own career aspirations.

Because CHCs use their resources to provide a great deal of care to individuals who have few resources, they operate with narrow financial margins. Their few reserves are often reinvested in service expansion. Despite these financial constraints, CHCs have turned out to be resilient organizations that provide stability of employment to thousands of people living in low-income communities across the state.

In aggregate, CHCs represent an important service industry in Massachusetts. In 1995, they generated $275 million in revenues and employed 6,600 people. More than 80 CHC service sites are now located in low-income communities throughout Massachusetts. CHCs core mission is to provide accessible community-oriented primary health care services to individuals and families who would otherwise have difficulty gaining access to needed health care. In achieving this mission, each health center has become a business employing an average of 100 individuals, purchasing supplies and services from local firms, and pumping an average of $4 million through the local economy -- mostly in the form of wages to local families.

Capital Projects and Ensuing Job Creation

Most CHCs in Massachusetts opened between 20 and 30 years ago, and operate in inadequate or outgrown facilities -- many of which were not originally designed as community health centers. As a result, CHCs are currently engaged in significant capital development activity as they pursue the replacement or expansion of their buildings. This recent growth and replacement of facilities is the source of a new and intensive period of economic stimulation in low-income communities. In several instances, the capital development and facility expansion of health centers is providing the impetus or focus of a broader economic rebirth in the local economy, and serving as an anchor for community investment.

Case # 1: Codman Square

Codman Square Health Center, located in the Dorchester neighborhood of Boston, recently completed a $5.5 million project to relocate the center from a converted library branch where it was housed for its first 20 years. It now operates from a new 29,000 square foot facility specifically designed to provide efficient primary care and supportive services. This facility has tripled the amount of space available for services, and has improved the patient comfort and efficiency of its operation. During the course of construction, this $5.5 million project generated an estimated 50 construction jobs.

Since the new facility opened in November of 1993, the center has increased its staff by 33 percent, adding 40 employees at the professional and support staff levels. The health center is currently the largest employer in the Codman Square neighborhood. In FY 95, the center provided 82,000 visits to 16,921 patients, representing a 20 percent increase in its patient base in one year.

The health center's revitalization has catalyzed other positive economic growth in the community. In the year following the health center's expansion, 32 new businesses opened in Codman Square -- more new business starts than in any other neighborhood of the city of Boston. Some of these new businesses, including a new pharmacy across the street from the health center, have located in Codman Square as a direct result of the health center's expansion. Many other businesses in Codman Square benefit from the foot traffic that the health center generates and from the services that the health center purchases.

In the words of Darlene Hodges, a Codman Square resident:

> The renovated health center makes the neighborhood a better place that people want to live in. Now, lots of other businesses are improving their buildings and having their signs done over. For instance, H&R Block, the travel agency next door to it, and the insurance company all had their signs in front of their buildings redone in green with gold lettering by the same person. There's more work to be done, but it's a start.

Case # 2: Lynn, Massachusetts

Lynn Community Health Center, located in a particularly blighted area of Lynn and serving a predominantly poor population, invested $2.3 million in the purchase and renovation of a vacant building in downtown Lynn, expanding their space from 11,000 to 30,000 square feet. In 1994, the center's first year of operation after moving to the new facility, the center's budget grew from $3.5 to $5.7 million and it added 32 new staff positions. The center's operation has continued to grow at an average rate of 23 percent each year since the renovation, its staff growing from 114 to 186 in that period of time. With a history of investing significant resources in hiring and training local residents in the health care professions, Lynn CHC employs approximately 85 percent of its staff from the local community. Located in an increasingly multi-ethnic city, 48 percent of its staff is bi-cultural as well.

The center provided 75,000 patient visits this past year, bringing increased foot traffic to the area. As in Codman Square, other businesses were attracted to the area. A Walgreen's Pharmacy opened a 20,000 square foot store within one block of the center last year; and Eastern Bank, which had operated a small branch across the street from the health center, added another 50 employees by moving its regional processing center to that site.

Other Examples

There are many similar recent instances of the dramatic impact of CHC capital expansion on the economic life of local communities. A sampling includes:

- Dimock Community Health Center in the Roxbury neighborhood of Boston is conducting an ambitious revitalization of its health and human services campus, resulting in significant increases in jobs and access to needed services.

- East Boston Neighborhood Health Center recently stepped in to mitigate the impact of the closing of Winthrop Hospital by opening an ambulatory care center in its place. It has completed the renovation of one abandoned school building into apartments for the elderly, and is beginning a similar conversion of another empty school building.

- Greater New Bedford Community Health Center has solved the community's problem of an abandoned building in the center of the downtown business district, successfully completing the construction of a new facility in its place that has both increased jobs and investment in the community.

- Dorchester House Multi-Service Center in the Field's Corner neighborhood of Boston has been a partner with the local CDC in the development of needed senior housing.

- Geiger-Gibson Community Health Center's new facility at Columbia Point was built through the center's participation in a successful mixed-income housing redevelopment, transforming the troubled Columbia Point Housing Project into a safer and more stable community that continues to house low-income families.

- Great Brook Valley Health Center in Worcester has successfully completed the first phase of its capital expansion plan, building a new facility next to the public housing project which it has traditionally served.

- Family Health and Social Service Center, also in Worcester, has completed a $4 million rehabilitation of a former Worcester City Hospital building, creating a much-needed primary care and urgent care center out of a building that might otherwise have been abandoned.

- North End Community Health Center in Boston's North End built, owns, and operates a nursing home within its rapidly changing community with a large elderly population.

- Fenway Community Health Center in Boston's Fenway area built a new facility enabling it to expand its community-based primary care and nationally respected programs in HIV services and research.

- Greater Lawrence Family Health Center completed a large new building in 1994, expanding its services and supporting its ability to train physicians in a unique community-based Family Practice Residency Program.

Each successfully completed development project resulted in new jobs during construction, the creation of permanent jobs resulting from the expansion of the health center's space and services, and direct investment in local communities. They have helped to eliminate blight and have reversed earlier patterns of disinvestment. Successful CHC development efforts provide incentives for the opening of other businesses that provide goods and services to health centers, employees and patients.

Job Creation, Training and Career Building

As part of their human and economic development mission, some community health centers have made a long-term commitment to training community residents in health care careers through innovative training programs. An exemplary model in health care career training has been developed by the Dimock Community Health Center. Dimock CHC currently trains dental assistants, surgical technicians, nurses aides, mental health and mental retardation counselors, and medical billing clerks. Over the years, Dimock CHC has trained over 3,200 people, many of whom have found fulfilling work at CHCs, local hospitals, and other health care facilities. Current graduates from Dimock CHC programs can expect to begin work earning from $8.25 per hour as nurses aides to $13.00 per hour as surgical technicians.

While Dimock CHC is exceptional as a direct provider of formal adult career education, all CHCs are integrally involved in bringing individuals from the community into health care related careers by virtue of hiring community residents and training them to fill many complex roles within the agency. The lives of many families have been affected through the career path opportunities they established at their local community health center.

Murielle Rue and Family

After her husband's death, Murielle Rue raised seven children as a single parent in a public housing project in Dorchester. She is now the director of medical records at the health center located in the project, where she has worked for the past 26 years, beginning as a medical record assistant. Her children are now grown and living independently; and she is a grandmother of 10, and great-grandmother of two.

Her daughter Michelle is a licensed nurse who oversees managed care activity and a maternal and child health program at another Dorchester community health center. Michelle got her first job filing charts in the medical record room where her mother worked. Her interest in providing direct health care was tested and strengthened as she later trained as a dental assistant and then as a medical assistant at the health center, assisting the same pediatrician from whom she had received her pediatric care. Murielle's oldest daughter Margo and her son Brandon both work in the field of medical billing. Her daughter Tonie works as a medical secretary to an orthopedic surgeon at the Massachusetts General Hospital. Her son Duane is attending graduate school in a non-medical field in California.

For this family raised in a troubled public housing development, the health center served as the source of health care for all family members, the source of employment and career advancement for the primary wage earner, and the source of mentors and professional role models and formative entry-level training in health care for the children. Resources invested have been amply repaid as each member of the family endeavors to "give back" to the community through careers in the health field and by mentoring others in the workplace.

Ruth McSharry and Family

Ruth McSharry, mother of five, and grandmother of six, is retiring this year from her role as senior patient accounts representative at a community health center after 25 years of supervising and mentoring the work of entry-level staff in reception and patient accounts. From her living room window, she can see the health center that she and some of her equally-committed neighbors helped to found in 1970.

Following in their mother's footsteps, her adult daughters have each worked in a variety of roles at a number of CHCs in the Boston area. Peggi worked her way through a nursing certificate program, and then continued as a part-time student to complete an associate's degree and become a registered nurse. She has worked for the past 10 years as a nurse at three different health centers, more recently moving into clinical leadership roles. Ruth's daughters Beth and Jennifer have worked at CHCs in medical billing and outreach roles. Peggi, her brother Sean, and her sister Colleen, who has an administrative role at another CHC, are all college graduates -- the first generation of this family to attend college. Having literally grown up at the community health center whose board first met around their kitchen table, these young adults benefited from role models and early employment opportunities afforded them by their CHC -- opportunities they have repaid with service and commitment to their neighbors.

CHC-Based Support Programs for Families

In addition to providing direct health care and job training, CHCs also provide a wide range of human services that help individuals to participate in gainful employment. These programs include:

Child Day Care Services for parents who are working or attending education and training programs enable them to acquire employment skills. These programs are administered by the community health center or are provided at community health center sites by other organizations. Dimock Community Health Center in Roxbury, Geiger-Gibson Community Health Center in Dorchester, and the Brookside Community Health Center in Jamaica Plain all offer these services.

Teen Programs are available at a number of health centers, providing positive mentoring relationships outside of the family. These programs are often recreational in nature and are aimed at providing a positive context for contact with peers. A number of centers offer specialized programs for teens at risk of school failure and drop-out, for pregnant and parenting teens and their infants, and for teens at high risk of substance abuse. CHC programs provide structure and support for completing high school and for developing employment skills and goals. The Teen Coalition of Lowell Community Health Center, the Adolescent Life Options Program (ALOP) at Roxbury Comprehensive Community Health Center, the teen program at Great Brook Valley Health Center in Worcester, the Dimock Teen Center, and the Mo Vaughn Youth Center at Harvard Street Neighborhood Health Center are some of the better-known programs. Many other CHCs also have active programs aimed at youth opportunity and support.

Substance Abuse Prevention/Intervention Programs are provided at many CHCs and are uniquely and effectively integrated with primary health care services. These programs directly address substance abuse, which is one of the causes and consequences of economic marginality in all communities. Effective prevention and recovery support is integrally tied to the ability of individuals and families to take advantage of the opportunities for economic advancement through education or training.

Women, Infant, and Children's (WIC) Nutrition Programs are administered by more than half of the CHCs in Massachusetts. These programs seek to assure adequate nutrition to infants and young children as well as to pregnant and post-partum women. They assess need and eligibility and provide nutrition counseling as well as vouchers that enrollees use to obtain milk and baby formula. WIC programs have grown dramatically under the administration of CHCs, and have brought cash-equivalent federal resources to poor families and into poor communities that would otherwise have been unavailable.

Quantifying the Impact of CHCs: Local Dollars and Local Jobs

The previously-stated, aggregate health center impact on Massachusetts is an important contributor to the state's economy -- 4,800 full time equivalent jobs, 6,600 employed individuals,

and $260 million in expenditures pumped into low-income communities across the state, including $185 million in payroll expenses.[1]

Summary of FY 1995 Direct Economic Activity of CHCs	
Total Operating Revenues	$275,000,000
Total Operating Expenses	$260,000,000
Payroll Expenses	$185,000,000
Individuals Employed	6,600
FTEs Employed	4,800

Multiplier Effects

From a macroeconomic perspective, dollars spent by CHCs have a greater impact when viewed in the context of the additional output and jobs they stimulate in other industries. Economists describe and measure aggregate economic impact of investments in an economy by computing and applying area and industry-specific "multipliers." Multiplier effects vary depending on the industry and the geographic area in which funds are expended, and are calculated and reported by the U.S. Department of Commerce through the Regional Input-Output Modeling System (RIMS II).

Multiplied Impact: Massachusetts

Economic multipliers for health care activity are high in comparison to other industries, making dollars spent by CHCs among the most productive in supporting the local economy. When the Commerce Department multipliers are applied to the aggregate CHC activity in Massachusetts reported above, the actual economic impact of the $260 million spent by CHCs in 1995 represents approximately $545 million in direct economic output, and $235 million in household income, ultimately supporting 10,000 jobs in Massachusetts.[2]

Summary of FY 1995 Indirect Economic Activity Stimulated by CHCs	
Total Output	$545,000,000
Aggregate Household Income	$235,000,000
Jobs Supported	10,000

Conclusion

In addition to providing critically needed, high-quality, community-based health care to low-income residents of the Commonwealth, community health centers provide training and employment for significant numbers of local residents, creating a foundation for local economic investment and stable communities. Economic expansion, coupled with improved access to health care, makes investment in CHCs one of the most productive possible uses of capital dollars.

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[1] Source: Massachusetts League of Community Health Centers (MLCHC) Survey of CHCs, 2/96

[2] RIMS II Multipliers for Massachusetts Health Care Industry: Total Output Multiplier = 2.1089 (multiplied by total operating expenses), Earning Multiplier = .91(multiplied by total operating expenses), Jobs Multiplier = 35.6 (multiplied by total operating expenses/1,000,000)

MASSACHUSETTS LEAGUE of COMMUNITY HEALTH CENTERS

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Economic Impact of Boston Community Health Centers

The city of Boston is the largest city in Massachusetts and in New England. The 1990 population of over 574,000 residents represents just under 10 percent of the total population of the state. Within the city, 26 community health centers operate at 34 service sites which are located in Boston's low-income communities. Both individually and as a whole, they make a concentrated economic impact on the city.

In 1995, Boston CHCs generated $175 million in health care services and expended $165 million in the process. Of this $165 million in operating expenditures, $115 million represented salary and benefits to employees, most of whom live in Boston. Community health centers in Boston directly employ 4,200 individuals in 3,000 full-time equivalent (FTE) positions.

Of these 26 health centers, six have main or satellite sites within the Boston Enhanced Enterprise Community (EEC) designated by the Department of Housing and Urban Development as a target for federally-supported efforts at intensive economic development. An additional eight are located in census tracts immediately abutting an EEC census tract, serving individuals living within the EEC. Counted together, these 14 health centers located in or next to the EEC generated $90 million in health care services in 1995, slightly over half of the $175 million generated by CHCs throughout the city. They expended $60 million in payroll costs out of $85 million in total costs, and employed 2,100 individuals in 1,400 FTE positions.[1]

Summary of FY 1995 Direct Economic Activity of Boston CHCs			
	Massachusetts CHCs	Boston CHCs	Boston EEC Impacting Sites[2]
Total Operating Revenues	$275,000,000	$175,000,000	$90,000,000
Total Operating Expenses	$260,000,000	$165,000,000	$85,000,000
Payroll Expenses	$185,000,000	$115,000,000	$60,000,000
Individuals Employed	6,600	4,200	2,100
FTEs Employed	4,800	3,000	1,400

Multiplied Impact: Boston

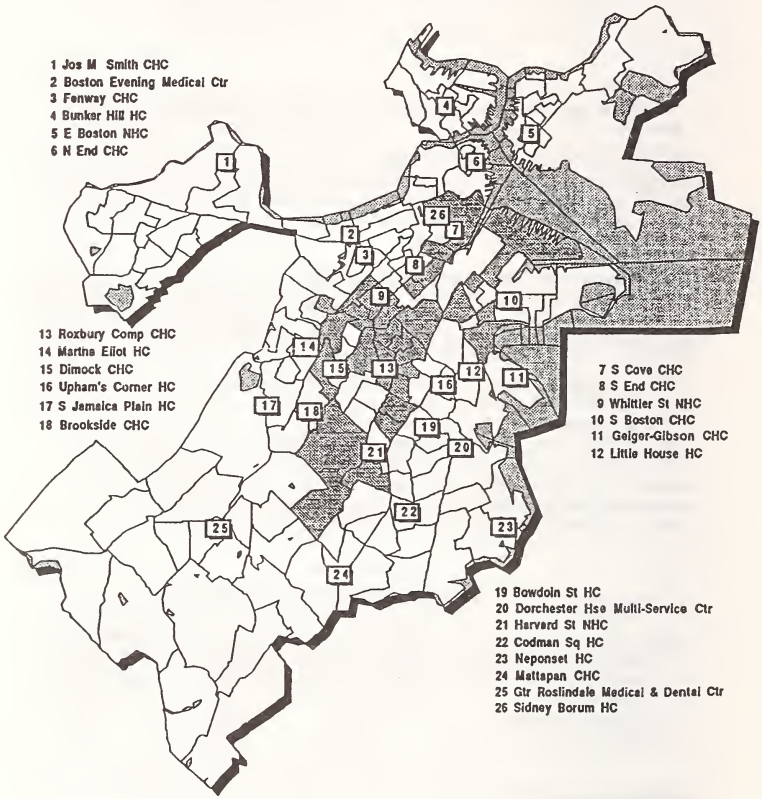
When "multipliers" are factored in to estimate the spin-off activity from the expenditures of Boston CHCs in providing health care services, the impact is particularly substantial. Boston's 26 CHCs stimulate more than $345 million in total economic output, fueling 6,400 jobs. The 14 EEC-impacting sites in Boston alone contribute almost $180 million in total economic output to their communities, generating 3,200 jobs.

Summary of FY 1995 Indirect Economic Activity Stimulated by Boston CHCs			
	Massachusetts CHCs	Boston CHCs	Boston EEC Impacting Sites
Total Output	$545,000,000	$345,000,000	$180,000,000
Aggregated Household Income	$235,000,000	$160,000,000	$80,000,000
Jobs Supported	10,000	6,400	3,200

[1] Source: MLCHC Survey of CHCs, 2/96

[2] "Boston EEC Impacting Sites" are defined as those health centers that have either main or satellite sites in one or more designated EEC census tract, or immediately abut an EEC census tract and serve residents from the EEC designated area.

Boston Enhanced Enterprise Community Census Tracts



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Economic Impact of Lowell Community Health Center

Lowell is the Commonwealth's fifth largest city, with a population of over 103,000. Lowell also ranks second highest among U.S. cities with an estimated 23,100 of its total population represented by residents who are from Southeast Asia, making 22 percent of Lowell's residents of Southeast Asian origin.

Lowell Community Health Center, operating a comprehensive service site located in Lowell's Acre neighborhood, provides a wide range of health and outreach programs to the Greater Lowell area. The health center serves a cross-section of its community: 34 percent of its patients are Southeast Asian, and 48 percent are Latino. In addition to its core primary care services, it operates a 32-bed detox unit, an outpatient substance abuse counseling program and an adolescent health program. It is a major provider of HIV+ care in the Lowell area, presently serving over 350 adults and 17 pediatric HIV clients. The health center provides culturally focused obstetric care to Lowell's multi-cultural community and is responsible for 350 to 400 high-risk deliveries each year. In 1995, 37 percent of its deliveries involved teen parents.

The health center is located in the Lowell Enterprise Community (EC) designated by the Department of Housing and Urban Development as a target for federally-supported efforts at intensive economic development. Lowell CHC is also an important contributor to the economy of Lowell. In 1995, Lowell CHC generated $6.2 million in health care services and expended $3.2 million in payroll expenses in the process.[1] It employs 151 individuals in 132 full-time equivalent (FTE) positions, and 83 percent of its employees come from the neighborhood. Lowell CHC is a major enterprise in the Acre, providing an important source of employment in the area and of foot traffic supporting businesses located around the health center.

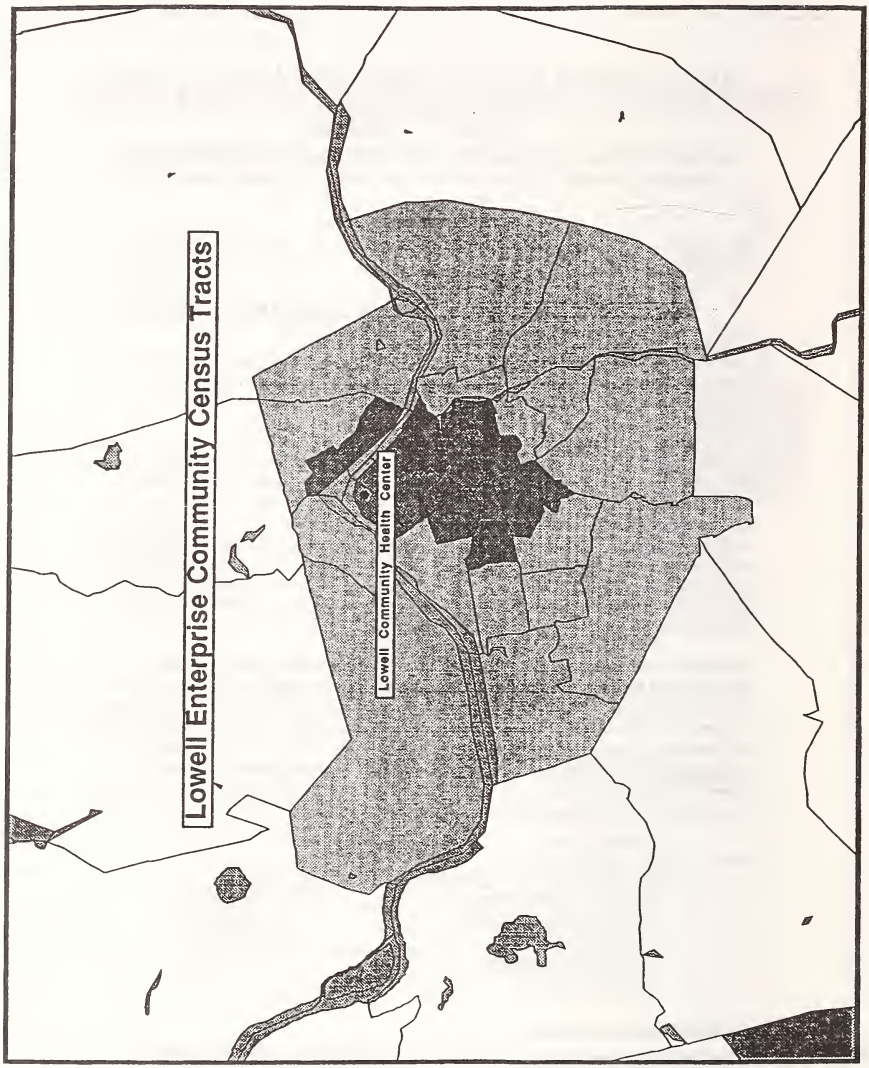
Summary of FY 1995 Direct Economic Activity of Lowell CHC	
Total Operating Revenues	$6,200,000
Total Operating Expenses	$6,170,000
Payroll Expenses	$3,200,000
Individuals Employed	151
FTEs Employed	132

Multiplied Impact: Lowell

When "multipliers" are factored in to estimate the spin-off activity from the expenditures of Lowell CHC in providing health care services, the health center's impact is particularly substantial. The community health center stimulates more than $12 million in total economic output, fueling an estimated 240 jobs in the city of Lowell.

Summary of FY 1995 Indirect Economic Activity Stimulated By Lowell CHC	
Total Output	$12,200,000
Aggregated Household Income	$5,600,000
Jobs Supported	240

[1] Source: MLCHC Survey of CHCs, 2/96


Lowell Enterprise Community Census Tracts
Lowell Community Health Center

MASSACHUSETTS LEAGUE of COMMUNITY HEALTH CENTERS

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Economic Impact of Springfield Community Health Centers

With a 1990 population of almost 157,000, Springfield is the third largest city in the Commonwealth, the largest city in Western Massachusetts, and ranks as New England's fourth largest urban concentration (behind Boston, Providence and Hartford). The city gained more than 4,500 residents from 1980 to 1990 -- 92 percent of this increase occurred in low-income neighborhoods within the Springfield Enterprise Community (EC) designated by the Department of Housing and Urban Development as a target for federally-supported efforts at intensive economic development.

Brightwood Health Center and Neighborhood Health Center are two community-based health centers of the Baystate Medical Center. Springfield Southwest Community Health Center opened for service in 1994 as a federally-funded Section 330 center. In addition to their core primary care services, each of the three CHCs provides a wide range of health and outreach programs within economically depressed and medically underserved Springfield neighborhoods. All three CHCs are located in the EC and will be an integral part of the overall effort to revitalize the inner city.

As well as providing essential health services to their communities, all three community health centers are important contributors to the economy in Springfield. In 1995, Springfield CHCs generated $4 million in health care services, expending more than $2.7 million in payroll expenses in the process[1] (which represented 68 percent of their combined expenditures). The three CHCs employed 95 individuals in 86.7 full-time equivalent (FTE) positions and a large percentage of these employees resided in the area they served. Springfield CHCs are a major enterprise in the area, providing an important source of employment in the area and of foot traffic supporting businesses throughout Springfield.

Summary of FY 1995 Direct Economic Activity of Springfield CHCs	
Total Operating Revenues	$4,004,333
Total Operating Expenses	$3,967,767
Payroll Expenses	$2,723,517
Individuals Employed	95
FTEs Employed	86.7

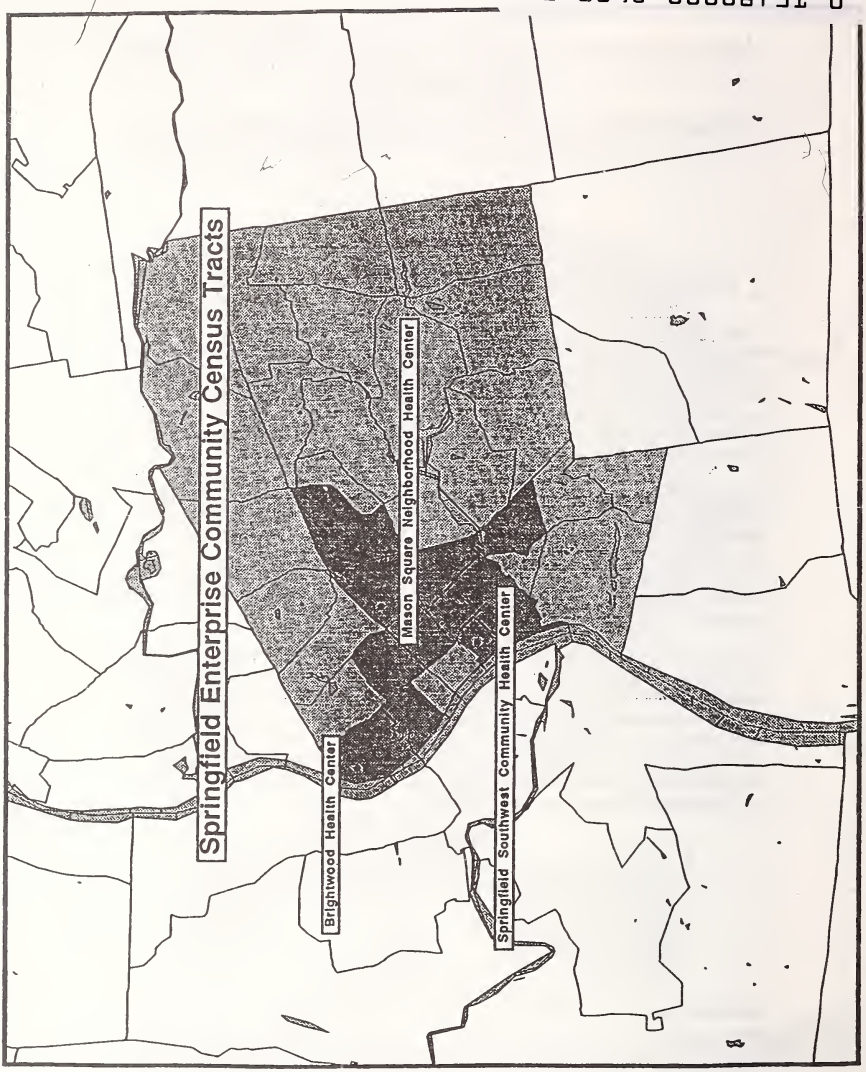
Multiplied Impact: Springfield

When "multipliers" are factored in to estimate the spin-off activity from the expenditures of Springfield community health centers in providing health care services, the economic impact is substantially increased. Specifically the three community health centers stimulated more than $8.3 million in total economic output, provided aggregate household income of $3.6 million and accounted for an estimated 153 jobs in the city of Springfield.

Summary of FY 1995 Indirect Economic Activity Stimulated By Springfield CHCs	
Total Output	$8,367,624
Aggregated Household Income	$3,610,668
Jobs Supported	153.2

Note: significant CHC capital expansion activity is underway at the two Baystate centers and a $4 million to $6 million capital expansion is planned for Springfield Southwest CHC. The multiplier effect shown above will be significantly enhanced by these facility development activities and have a direct impact on increased household income and jobs.

[1] Source: MLCHC Survey of CHCs, 2/96, member communications



[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

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